VA HEALTH CARE DELIVERY FACILITIES IN THE MIDWESTERN MEDICAL REGION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

OCTOBER 22, 1983

Serial No. 98-34

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
29-443 O WASHINGTON : 1984

H761-9

COMMITTEE ON VETERANS' AFFAIRS

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
BOB EDGAR, Pennsylvania
SAM B. HALL, Jr., Texas
DOUGLAS APPLEGATE, Ohio
MARVIN LEATH, Texas
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
WAYNE DOWDY, Mississippi
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
FRANK HARRISON, Pennsylvania
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, Jr., West Virginia
J. ROY ROWLAND, Georgia
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
BILL RICHARDSON, New Mexico

JOHN PAUL HAMMERSCHMIDT, Arkansas
CHALMERS P. WYLIE, Ohio
ELWOOD HILLIS, Indiana
GERALD B. H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
DENNY SMITH, Oregon
PHIL GRAMM, Texas
DAN BURTON, Indiana
DON SUNDQUIST, Tennessee
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut

Mack Fleming, *Chief Counsel and Staff Director*

Subcommittee on Hospitals and Health Care

BOB EDGAR, Pennsylvania, *Chairman*

DAN MICA, Florida
WAYNE DOWDY, Mississippi
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
FRANK HARRISON, Pennsylvania
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, Jr., West Virginia
J. RAY ROWLAND, Georgia
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
BILL RICHARDSON, New Mexico
THOMAS A. DASCHLE, South Dakota

JOHN PAUL HAMMERSCHMIDT, Arkansas
ELWOOD HILLIS, Indiana
GERALD B. H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
PHIL GRAMM, Texas
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut

CONTENTS

October 22, 1983

Page

VA Health Care Delivery Facilities in the Midwestern Medical Region 1

OPENING STATEMENTS

Chairman Bob Edgar 1

Hon. John Paul Hammerschmidt 3

WITNESSES

Galloway, Alfred P., senior vice commander, American Ex-Prisoners of War; accompanied by Mr. Jack Brady, junior vice commander for the western zone 5

  Prepared statement of Mr. Galloway 61

Glade, Edward G., service officer, Department of Colorado, Veterans of Foreign Wars 22

Norman, McKinley, commander, Department of Colorado, Disabled American Veterans; accompanied by Mr. John Bickerton, senior vice commander, Department of Colorado; Mr. John Wiedeman, adjutant, Department of Colorado; and Mr. Lennox E. Gilmer, service advocate, Department of Colorado 10

  Prepared statement of Mr. Norman 64

Mullon, Thomas P., Director, Midwestern Region, Department of Medicine and Surgery, Veterans' Administration; accompanied by Mr. Carlton Smith, Director, Veterans' Administration Medical Center, Denver, Colo.; Mr. William Freer, Director, Veterans' Administration Medical Center, Grand Junction, Colo.; Mr. Charles Beck, Director, Veterans' Administration Medical Center and Regional Office, Cheyenne, Wyo.; Mr. Jonathan Fitts, Director, Veterans' Administration Medical Center, Ft. Lyon, Colo.; and Mr. Robert Lindsay, Director, Medical District 24 and Director, Veterans' Administration Medical Center, Salt Lake City, Utah 33

  Prepared statement of Mr. Mullon 87

  Prepared statement of Mr. Lindsey 92

  Prepared statement of Mr. Smith 170

Stewart, Robert W., contractor, veterans' readjustment counseling program 25

  Prepared statement of Mr. Stewart 85

Van Antwerp, Brenda, service officer, Department of Colorado, the American Legion; accompanied by Mr. John Kover, adjutant, Department of Colorado; and Mr. Pat Smith, National Executive Committee, the American Legion 15

  Prepared statement of Ms. Van Antwerp 82

Written committee questions and their response: ....

  Hon. John Paul Hammerschmidt to Mr. Thomas P. Mullon, Director, Department of Medicine and Surgery, Midwestern Region, Veterans' Administration 56

VA HEALTH CARE DELIVERY FACILITIES IN THE MIDWESTERN MEDICAL REGION

SATURDAY, OCTOBER 22, 1983

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:30 p.m., in University of Colorado School of Nursing, room 1951, 4200 East Nineth Avenue, Denver, Colo., Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar and Hammerschmidt.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. Good afternoon.

The Subcommittee on Hospitals and Health Care will come to order.

On behalf of the subcommittee, I wish to welcome each of you to this oversight hearing on the VA's health care delivery facilities in the VA's midwestern medical region. The subcommittee has completed four of a series of six oversight field hearings during this session of the 98th Congress. In addition to this hearing, we will conduct one more in San Francisco in November. In each of the hearings, we receive testimony from the director of the medical region.

Earlier today, we toured the Denver VA Medical Center where a $54 million construction project for a new clinical support wing and fire and safety upgrades is underway. It is anticipated construction will be completed in 1986.

Tomorrow morning we will tour the VA Medical Center in Albuquerque and in the afternoon attend a veterans' forum in Sante Fe, N. Mex. which has been arranged by Congressman Richardson.

This series of oversight hearings is particularly important at this time due to the crossroads that the VA health care delivery system faces in the next 5 to 6 years in providing quality and quantity medical services to eligible veterans. In the eight VA medical centers in medical district 24 of this medical region, there has been allocated in the current fiscal year almost $154 million and 4,454 employees to provide health care to eligible veterans.

Medical district 24 will serve 463,917 veterans in fiscal year 1984. By 1990, it is estimated that this figure will increase to 598,178. However, over the same period the number of veterans 65 years or older will increase to 167,000 to 22 percent of the population. Nationwide, the VA has estimated that demands placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years.

By 1990 alone, more than one-half of all American men over age 65 will be veterans. Right now, due to unemployment, more and more veterans are coming to the VA for the first time. These facts indicate that we not only have a present problem but a future problem in maintaining the quality and quantity of care. The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also for hospital care resulting from acute episodes of chronic illnesses in the older veteran.

We must cope with the present demand but, most important, we must be prepared to accommodate the future demand on the system as well.

We must also be alert to respond to the unique and changing needs of many other segments of the veteran population. For instance, we must address the continuing serious readjustment problems faced by thousands of Vietnam-era veterans. As we go through the hearings today, you will discover we are really interested in some long-term vision.

What kinds of innovative health technology and methods can we provide to negate the need for additional in-house or institutional settings for providing the health care. Are there some creative ways we can provide the same kind of health care with the relationship in terms of home nursing services or home health care in creative ways.

The House Committee on Veterans' Affairs is, in my view, the most bipartisan committee in the U.S. Congress. However, we can't operate without the cooperation of veterans' service organizations and individual veterans. The VA's health care and other benefit programs have been enacted by the Congress as the will of a grateful Nation for the sacrifices these veterans made in serving in the Armed Forces of the Nation.

But apart from that, the American people as a whole have greatly benefited from the investment in VA services and facilities. The VA medical budget for fiscal year 1984 is approximately $8.1 billion. However, that figure represents only about 2.5 percent of all national health care expenditures. At the same time the VA has provided part of the training, through its affiliations with the private medical community, for more than one-half of all health care professionals in the United States.

VA researchers have already received two Nobel Prizes in medicine. The medical research program has been responsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthroughs in kidney transplants, cancer research, renal disease, hypertension, and psychiatry, to name only a few.

Three of the eight medical centers in medical district 24 have active research programs and have been allocated approximately $3.6 million in fiscal year 1984 for VA-funded research. The VA is the nation's largest health care provider with 172 strategically located hospitals and 226 outpatient clinics serving as the primary backup to the Department of Defense medical system in time of war or national emergency. The investment made in the VA is more than returned in kind.

This is our first opportunity to learn how VA health care is delivered in a rural setting to veterans living in areas remote from VA medical centers, and we're anxious to learn if veterans in such areas are being served properly.

For those of you who are testifying, we are very pleased to have you here. We will be asking each to come to the witness table and present your statement. You can either read your statement to us or, if you would like, your full statement will be made a part of the record and you can just lift up the highlights for us.

I would now like to recognize the ranking minority member of the subcommittee, as well as the full committee, the Honorable John Paul Hammerschmidt of Arkansas.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I want to again congratulate you on scheduling this series of field hearings for our Subcommittee on Hospitals and Health Care. Such hearings give our members an insight into the VA medical care program which we simply cannot obtain by viewing that program only from the Washington scene.

Mr. Chairman, you have outlined the purpose of our visit to this area. You have made reference to several basic medical issues facing the veterans of our Nation. You mentioned the medical needs of the aging veteran and the rehabilitation needs of Vietnam veterans. Certainly these kinds of issues must command our immediate attention if we are to adequately prepare for the future. That future even now is almost upon us.

Mr. Chairman, other perplexing issues also concern our committee. The Department of Medicine and Surgery of the Veterans' Administration is just now really entering the vast field of medical computerization. For far too long it debated the route it would take. Fortunately, under the leadership of its new Administrator, Mr. Harry Walters, VA is moving rapidly ahead. We have seen evidence of this as we have visited medical facilities across the country, and we saw and heard about it again this morning as we toured the Denver VA Hospital.

Mr. Chairman, the VA medical program is housed in a variety of facilities. Some are very new, some very very old, and some are in between. Recognizing that state of the art treatment requires modern up-to-date facilities, our committee over these past few years has authorized very large construction budgets for the VA.

Here in Denver at the medical center will be seen examples of what is being done. The new clinical addition and the new nursing bed unit will enable this fine facility to continue its excellent programs. Throughout this entire medical district similar activity is taking place or is planned at Cheyenne, and Sheridan, Wyo.; at Grand Junction, Colo.; at Fort Harrison, Mont., and at Salt Lake City, Utah. All of us can take pride in these needed construction projects for they clearly show our Nation's commitment to keep our veterans' medical programs at a high level of compassion and efficiency.

Mr. Chairman, the VA medical district that includes Denver is rather unique in that it is spread over an extremely large area and includes a number of hospitals in rural areas and in small towns. A number of them are not affiliated with medical schools and probably have recruitment and other difficulties.

I would hope that our witnesses today would touch on any problems that may exist in the district because of these factors and that they would inform us of any initiatives being pursued to meet them.

Mr. Chairman, again I congratulate you for having this hearing and I join with you in a warm welcome to our witnesses.

Thank you, Mr. Chairman.

Mr. **Edgar**. Before we begin, I want to thank you for your participation in the hearings. I don't remember any subcommittee of the Veterans' Affairs Committee that has traveled as far as we have, and I don't know of any Member who has done as much work as you have done in trying to provide for the health care needs of veterans.

I really appreciate your presence here and your participation in our subcommittee.

Before we begin with our witnesses, these hearings can't be done without a great support staff. The gentleman to my left is Jack McDonell, the counsel for the subcommittee on the House side. We have several staff people here if you have individual concerns afterwards you would like to mention to them.

Rich Fuller from my staff is here, and Barbara Daniel is here, also from the full Committee on Veterans' Affairs staff. And we also have with us Victor Raymond, from Senator Alan Simpson's staff. We have met on several occasions with Senator Simpson and are very pleased with the cooperation that we are getting, particularly on our health care bill which we hope will pass both the House and Senate next week. I am putting in a plug for that, and I hope you will take that message back to the Senator.

We also want to thank our court reporter, Al Mills, who has come all the way from Washington to record this hearing, and the published hearing will be made available at a later date.

Our first set of witnesses will be Alfred Galloway, accompanied by Jack Brady. Al is senior vice commander of the American Ex-Prisoners of War. He is accompanied by Jack, who is junior vice commander for the western zone.

Mr. Galloway, Mr. Brady, we are pleased to have you here today. Please be seated.

As I indicated, we appreciate your taking the time and we ask you to speak into the microphones. The full text of your statement will be made a part of the record. We invite you to either read portions of it or summarize.

STATEMENT OF ALFRED P. GALLOWAY, SENIOR VICE COMMANDER, AMERICAN EX-PRISONERS OF WAR, ACCOMPANIED BY JACK BRADY, JUNIOR VICE COMMANDER FOR THE WESTERN ZONE

Mr. GALLOWAY. Thank you, sir.

I would like to ask your indulgence for just a minute, if you don't mind. May I stand and ask for something, please?

Mr. EDGAR. Yes.

Mr. GALLOWAY. Would all the ex-POW's in the room please stand?

Thank you.

My reason, of course, sir, was that while Jack and I are both national officers, we are from the Seattle area. Jack will probably do the presentation in San Francisco.

We also realize that this is the Denver area, and people that are in the Denver Mile-High Chapter and those from the Colorado Springs area, the Rocky Mountain Chapter, are also very definitely interested in what is going on here, not only for the ex-prisoners of war, but for veterans at large.

I would like to make at this time a couple of highlights from my presentation that will be part of the record, and then I have another smaller area that I would like to take up with you, if you don't mind, please.

Mr. EDGAR. You may proceed.

Mr. GALLOWAY. I have had conversations with people from the Dallas, Tex., area. I have talked with people from the Denver area. I have visited the VAMC in Helena, Mont. The feeling that I get from these various areas is somewhat nonunity. For example, by that I mean some of the areas that do their 97-37 exams, they take them into the hospital and review their case there. One other place, they are given a nurse practitioner to do the review. And in others they are given a thorough physical examination, but the Psychiatry exam leaves a little to be questioned.

Mr. EDGAR. If I may interrupt you—for those present, why don't you tell us about the 97-37.

Mr. GALLOWAY. Public Law 97-37 was a public law that was passed by Congress in August 1981, and signed into law in October of 1981. It was to upgrade certain benefits for the specific benefit of ex-prisoners of war, primarily in the anxiety and neurosis field.

I do not have a copy with me. I am sorry, sir. But this is primarily what it is about.

Mr. EDGAR. That is sufficient. I just wanted those not familiar with that provision of law to understand what you are talking about.

Mr. GALLOWAY. In April of this year the Veteran's Administration put out a new form which told in detail what kind of a history to ask for on the ex-prisoners of war. It was to be used for evaluation of their disease condition and also for the psychiatric condition. At this time the Ex-Prisoners of War organization has no argument as far as the physicals are concerned. Our primary concern is that many people go in and talk to a psychiatrist and are granted only a short time, and the psychiatrists are asked that a decision be made that is going to affect this man's life for a long time down the road.

In a statement that I have, one of the things that we came across was, and I will read this as we have it.

Public Law 97-37 was signed October 1981. Shortly thereafter instructions were sent to the field. Therefore it is possible that some of the POW's examined were short-changed. The reason for this statement is that VA form 10-0048 dated April 1983 was not in use. The examinations were not as thorough, certainly, and the history was not there. Therefore, 97-37 as it now stands today has not been effective long enough to tell whether amendments are needed.

It is believed physicals being given under present VA form 10-0048 are complete and thorough. This also pertains to the laboratory and related work.

What we believe is of greater importance is the psychiatric examinations. They will probably never be very good because the time allotted for them is much too short. For any psychiatrist to overcome the distrust and anger of a former prisoner-of-war, which has been built up for over 30 years of summary dismissals and having been ignored, it will take more time than is presently allotted. An almost universal trait among all former POW's is distrust. When talking with someone about their experiences as a POW, and their life since then, it is almost unheard of for them to talk to a complete stranger with any degree of depth or openness.

The question I ask is, Is it really possible for a psychiatrist to make a judgment in such a short interview? We do not think so.

We ask that this area remain open. There may be a need to ask Congress for help in this area. The treatment for this can be long-term in psychiatric areas. I believe this is an area where education is needed for both the doctor and the former POW. The doctor may need to learn to ask specific questions to start the former POW's to talk. The ex-POW needs to learn to talk to doctors and the VA.

A couple of other things I have run across in my talks with people about this particular item: One overall complaint seems to be that, regardless of how serious the director and his higher level staff may be, they have not convinced many of the clerks that many of the veterans have already paid a price for the care they are asking for. Most of these veterans do not feel well and the last thing in the world they need is some smart-aleck clerk behind the desk.

What appeared to be a good idea was observed at the Denver VAMC. It is a separate line for service-connected and nonservice-connected walk-in patients. If not that, then let it be known that service-connected cases on a routine walk-in basis are handled ahead of nonservice-connected.

The reason I bring these things up, gentlemen, I am thinking that in the case of all veterans and, quite frankly, there are an awful lot of the Vietnam veterans that are already today in situations like the POW's are, and it has not taken many years. Their problems are going to get tough.

Many veterans walk into a VAMC and see someone with a service-connected card and he is waiting, and someone else has a non service connected card and is being served. They do not feel they are being treated fairly.

Gentlemen, I thank you for giving us this time.

[The statement of Mr. Galloway appears on page 61.]

Mr. **Edgar**. Thank you very much.

Mr. Brady, do you have anything to add to that statement?

Mr. **Brady**. Thank you, Mr. Chairman.

Mr. Galloway has hit every area of the greatest concern to us as former prisoners and some of the areas which are of greatest concern to all veterans, particularly our younger ones now.

You mentioned one in your opening statement of the aging veteran. I would like to point out the majority of the former prisoners as of right now are in that category. And in addition to the various ills connected with having been a prisoner, there are also those which are going to be coming up connected with the process of getting older. I think that is something which also must be kept constantly in mind.

Thank you.

Mr. **Edgar**. Thank you.

Mr. Galloway, if I understand your statement correctly, the new directive, 10-0048, is a much more comprehensive analysis of ex-prisoners of war, is that correct?

Mr. **Galloway**. Yes, sir.

Mr. **Edgar**. What you are saying is that you like the new examinations, don't like the old examinations, and you want the ex-prisoners of war to have an opportunity to have at least access to the full examination?

Mr. **Galloway**. Yes, sir. That is one of our concerns. Since form 10-0048 has come in—the early exams may not have received a good history on POW's.

Mr. **Edgar**. And the psychiatric examinations are too short to make the kind of life decisions that are made by that analysis?

Mr. **Galloway**. I hate to smile when I answer your question, sir, but POW's, and I think many ordinary human beings are leery of talking to psychiatrists on a short term visit because they do not understand the language, shall we say, or whatever it is of psychiatry. It needs to be explained to them what this psychiatrist is looking for. And it takes, in my feeling, a feeling of trust.

I do not believe that an average veteran even walks into a psychiatrist's office and really tells him all about his daily life. You have to, I believe, have two or three visits at least.

Mr. **Edgar**. Let me ask you a specific question relating to the service-connected getting priority.

I generally support that concept. But I have a little bit of a problem, and that is, take a Vietnam veteran who may have believed very strongly that as a result of his service in Vietnam he has delayed stress syndrome, or a systemic disease related to exposure to the defoliant agent orange or one of the other defoliants that was used, and he is very emotionally upset about his physical condition and the inability to get immediate relief for that condition, regardless of the quality of care that he might be given.

I wonder if you have thought about those who fall between service-connected and non-service-connected. Aren't all those who served their Nation to some degree coming to the VA, not necessarily service connected, but connected in the sense of having given a commitment to the Nation?

Mr. **Galloway**. I think this, sir, would be one area where, as was mentioned about the clerks—they would have to take a look and see. I do not honestly believe that any service connected veteran would complain if this were the case. It is just something that many of them seem to feel on an ongoing basis.

Mr. Brady has a statement.

Mr. **Brady**. Mr. Chairman, I believe that we cannot possibly give you an answer as to how it can be done. But in the case of former prisoners, Public Law 97-37 puts former prisoners into a category which is somewhat special in that all of the ills, ailments, and complaints which we have will be handled by the Veterans' Administration, whether they are service-connected or not.

Now, I don't know how it can be done for those others you speak of, the Vietnam veterans. However, I believe that some type of a special category could possibly be devised for them, the same kind as has been devised by Congress for the ex-prisoners of war. I think the wisdom of Congress in its hearings can come up with something.

Mr. **Edgar**. Thank you.

Before I yield to my colleague, just a point of levity, a story I heard the other day, about the two psychiatrists that showed up at an event. They had both served in psychiatry for 20 years. One came into the room, very disheveled and clearly worn out. The other came into the room very neat and tidy and looking like $1 million.

One said to the other "How do you do that? For 20 years, sitting and listening to people's problems, how come it doesn't affect you?" The other psychiatrist said, "Who listens?"

I apologize for that moment of fun at psychiatrists.

I have a certificate in pastoral psychiatry. I am a minister by vocation and a Congressman by accident. I think there are a lot of good and bad stories that can be told about psychiatrists. There are also a lot of misconceptions about what they do.

I think you are right, there is a lot of fear and suspicion about what kinds of services they can provide. One of the interesting things is, we found a great number of the psychiatrists within the VA, throughout the VA system, to be very quality-minded and really trying to provide a service. Sometimes there has been limitations of time and space and staff. I think with the addition that is being made here in Denver, there should be at least some better space provided for the kind of psychiatric needs that are in house needs.

I appreciate your raising the issue.

I yield to my colleague.

Mr. **Hammerschmidt**. Mr. Galloway and Mr. Brady, we want to thank you for your appearance here. I don't have any questions.

You know, it is a fairly new law, just passed in the last Congress. Congress obviously wants it promulgated and administered in the way that they intended. Unfortunately, in a large system sometimes a lot of things fall through the cracks. Maybe the 10-0048 form will begin to clarify the situation some. But that is one of the reasons we are out here. We want to find that out.

We understand what you are telling us.

Let me drift a little bit afield. You know the Vietnam veteran outreach centers as we call them are not necessarily only for Vietnam veterans, However, we kind of relate them largely to the needs of the Vietnam veteran.

As we have gone around and talked to many of the people in those outreach centers, who may have delayed stress syndrome, it appears POW's may have been affected in the same way. It may have gone unrecognized—World War II POW's I am talking about. Do you know of any of your members from World War II that take advantage or go into those outreach centers, either give them support or have discussions with them? Or do you think there is any value in discussing this?

Mr. **Galloway**. I can speak for the city of Seattle. I myself have been down there and talked with them; not within the last year, I didn't have the time, but prior to that I had more time. I went down and talked with them. This is one of the reasons I brought it up—the Vietnam veterans are being affected already today like we were, only 40 years difference in time.

I think the psychiatry field is going to have a handle on this.

Mr. **Hammerschmidt**. In the extension of the centers and in the law Chairman Edgar is talking about, we are going to extend the authorization for those centers probably 4 years, because there is going to be a study made in the meantime. Just like this new legislation we put on the books for POW's—it takes a little while to evaluate these new programs.

But it just occurred to me, maybe those centers could speak to a far broader population than just the needs of the Vietnam veteran.

Thank you very much, gentlemen.

Mr. **Galloway**. I would just like to say one more thing. I would feel if more people could walk the Halls of Congress and stop and take a few moments time to listen to hearings, stop and talk to their Congressmen, and show a little more patriotism, we may not have some of the psychiatric problems we have today.

I thank you, gentlemen, for your time.

Mr. **Edgar**. Our next group of witnsses will be Mr. McKinley Norman, Mr. John Bickerton, Mr. John Wiedeman, and Mr. Lennox E. Gilmer.

Mr. Norman is commander of the Department of Colorado Disabled American Veterans and he is accompanied by Mr. Bickerton, senior vice commander; Mr. Wiedeman, adjutant, Department of Colorado, and Mr. Gilmer, service advocate, Department of Colorado.

Gentlemen, we are pleased to have you here.

Mr. Norman, again we invite you to abbreviate your statement as you see fit.

The full text of your statement will be made a part of the record.

STATEMENT OF McKINLEY NORMAN, COMMANDER, DEPARTMENT OF COLORADO DISABLED AMERICAN VETERANS, ACCOMPANIED BY JOHN BICKERTON, SENIOR VICE COMMANDER, DEPARTMENT OF COLORADO; JOHN WIEDEMAN, ADJUTANT, DEPARTMENT OF COLORADO AND LENNOX E. GILMER, SERVICE ADVOCATE, DEPARTMENT OF COLORADO

Mr. NORMAN. Mr. Chairman and members of the subcommittee, I appreciate this opportunity to appear before you today representing the Colorado Department of the Disabled American Veterans.

Because of the length of our written testimony, with your permission, I will summarize the major points and submit the written testimony for the record.

I would like to begin by introducing Mr. John Bickerton, senior. vice commander; Mr. John Wiedeman, department adjutant and Mr. Lennox Gilmer, department advocate.

I have asked them to accompany me to assist in answering any questions the committee may have.

Mr. Chairman, our testimony provides a lot of detail regarding the aging of our veteran population. However, in summary, let me restate here the fact that by the year 1990 veterans are projected to make up 60 percent of the male population over age 65. By the year 1995 there will be over 8 million veterans whose age exceeds 65 years. That will be a 234-percent increase over the number of veterans now 65 years of age or older.

We already know that as we age our medical problems will become more complex, will present themselves more often and will take longer to treat.

We are grateful for the Veterans' Administration's research aimed at geriatrics. However, we are concerned about the Veterans' Administration's ability to service all of its eligible veterans in the future with the increase in veteran geriatric needs. The system already appears to be straining to keep up.

With that background, we have certain matters we wish to bring to your attention.

From time to time we receive complaints about the length of time the Veterans' Administration takes to approve fee basis and structured authority for payment to private physicians.

We believe that one way to improve this situation is to make the Target computer system available to the Denver VA Medical Center Operation and Fee Section.

We are concerned that private physicians will be hesitant to participate if they are not reimbursed in a timely fashion.

The access to the Target computer system should speed up eligibility determinations.

We want to compliment the pharmacy for reducing the waiting time for dispensing medication to about an hour and for virtually eliminating complaints about their dispensing the wrong medication.

There has been significant improvement although we urge them on to more improvements.

One of the issues that is critical is staff morale. We have had three instances recently where disabled veterans were apparently discriminated against because of their handicaps.

We include the details in our written testimony. However, we wish to emphasize that perceived unfairness in personnel issues is extremely demoralizing, not only to the individual employees involved, but to other employees who may begin to question the agency's willingness to treat them fairly.

The three cases cited in our written testimony resulted in three handicap discrimination complaints; one has been resolved, one has gone to the next EEO step—a formal complaint—and one has been withdrawn.

While the Denver VA Medical Center has modified its hiring procedures in one case and hired the complainant in another case, it was unwilling to accommodate a veteran pharmacist with 20 years' experience who had a service-connected disability for deafness.

We applaud the VA veteran outreach program, and we take a great deal of pride in the private mental health professionals in Denver who have been considered national leaders in the treatment of post-traumatic-stress disorder.

However, we have the following concerns:

We would prefer seeing more contract money paid to private mental health professionals to serve veterans outside the commuting area of VA medical centers and outreach centers and their satellites.

We also want contract money to be used where a patient cannot use a Veterans' Administration facility although they may be within commuting distance.

The Grand Junction VA Medical Center, as an example, no longer provides therapy groups for the treatment of post-traumatic-stress disorder and there has been a contract let in their treatment area.

We believe that this will act as a disincentive for them to begin providing treatment in groups for posttraumatic stress disorder.

Finally, we are not seeing the Denver VA Medical Center drawing from the storefront experience to treat posttraumatic-stress disorder on the hospital wards.

While we continue to support the storefronts and a modified contract program, we believe that if these programs are to be continued beyond a few more years that the VA medical centers must begin to take more responsibility for treatment and management of these programs.

This week we received the Veterans' Administration response to a letter we wrote in April of this year. Because we wanted time to review this extensive package, we are not prepared to comment on that information today.

However, we would appreciate the opportunity to send additional views in writing if the record could be held open.

Mr. **Edgar**. Without objection, the record will be held open for those additional comments.[1]

Mr. **Norman**. Parking is an atrocious problem for the Denver VA Medical Center. Following construction in 1986, parking spaces are actually going to be reduced by 98 slots to 358. At the same time, there will be 1,270 full-time equivalent employees and a projected 179,000 outpatient visits. There are no hard plans to resolve this problem, even in the future.

---

[1] Not received at time of publication.

We were pleased to hear about the decision to add 60 nursing home beds to this VA medical center. However, this will not be enough nursing home beds.

We urge an increase in Federal funding for the State veterans nursing home program.

Although more than half the veterans in Colorado live in Denver, the certificate of need process will not allow construction of a State veterans nursing home in Denver.

For this reason, we urge title 38, United States Code, section 5035, be amended to provide for grants to cover up to 65 percent of the cost of acquiring and/or remodeling existing nursing homes.

Finally, we would like the number of contracts for nursing home care provided to patients being discharged from the Denver VA Medical Center to be increased.

Additionally, we want the Denver VA Medical Center to not only approve 3 months of care for non-service-connected patients, but to be more lenient in extending the contracts to 6 months home care, especially when nursing home care is required for health reasons.

We don't like to complain about issues around the Denver VA Medical Center construction because we are so pleased about the improvements that we know are coming.

However, we are informed that on certain days there just is not enough waiting room and seating. We believe this should be corrected.

Finally, we bring to your attention a concern about the VA's willingness to respond to our requests for information.

While the Denver VA Medical Center has improved recently in responding to our requests for information regarding individual cases, it still takes 6 to 8 weeks.

We still have inquiries that have not been answered, although the inquiry was mailed several months ago.

Another example of this problem is a general inquiry regarding the VA veteran outreach program which was mailed in April of this year. Since we have written our testimony, we did receive an answer this week, October 19, 1983—7 months later.

Thank you for inviting us to appear before you today. We appreciate your interest in our views.

If you have any questions, we would be pleased to respond to them.

[The statement of Mr. Norman appears on p. 64.]

Mr. Edgar. Thank you, Mr. Norman.

We are really fast legislators. We write legislation very quickly. We are probably the fastest in the whole world because, on page 6 of your testimony you state that you would like to amend title 38, United States Code, section 5035 to provide for grants for up to 65 percent for State nursing homes. That is already part of the law.

Mr. Gilmer. Mr. Edgar, we are actually asking for a slightly different thing.

Mr. Edgar. Are you going to modify that provision?

Mr. Gilmer. Yes.

The modification we are seeking would provide for the purchase of existing facilities. That only provides for construction. Now, the reason——

Mr. **Edgar**. It is not real clear in your statement there. If you read it quickly, it reads that you want 65 percent, but the focus on purchasing somebody else's nursing home, which is an area we have not gotten into——

Mr. **Gilmer**. We appreciate the opportunity to clarify that. We don't wish to improve someone else's nursing home. Our concern is that in the State of Colorado we presently have two State veterans nursing homes. We have an application in for a third, but in each case we have had to go into places way outside the Denver area, the reason being that in the State of Colorado, if we cannot get a certificate of need for nursing home beds in the area, the State will not allow a nursing home to be built in that area.

Now, although Denver has over 60 percent or over half the veterans in the State of Colorado, we cannot build a State veterans nursing home in Denver. The solution, we believe, or at least a possible solution, and the State has indicated they agree with this approach, would be for us to be able to purchase an existing facility, one which may not be doing well or one which, for some reason or another, would like to sell its nursing home.

Then it would allow us to remodel that facility, to bring it up to the standard for a State veterans nursing home so we could have one in the Denver area. It allows us to bypass the certificate of need process, would allow us to put more nursing home beds in this area where the State will not allow that at this time.

Mr. **Edgar**. Let me just make a comment and then raise another question with you.

You will be pleased to know the bill I made reference to, which will be passed in the House and Senate in the next 2 weeks, to provide for a 4-year extension of the readjustment counseling centers and a number of other things, increases—by the way, on the 4-year extension of readjustment counseling centers, that is a secret; it hasn't quite been made public yet.

Mr. **Gilmer**. It is a nice secret, thank you.

Mr. **Edgar**. But, anyway, getting back to that particular piece of legislation, Congressman Hammerschmidt and I and the other members of our subcommittee listened very attentively to the value in savings that we could make at the Federal level by having a better cooperative venture with the States in developing nursing homes.

We support the 65 percent for construction or modernization of facilities for State homes, and the rest of that, the 35 percent, for construction, modernization, comes from State governments.

In the bill that we provide, the Federal Government will increase its percentage of funding for nursing home care, domiciliary care for veterans who are in State homes.

We think that it should be in the neighborhood of about 30 percent of that care, with State providing 70 percent of the operation funds, and the Federal Government making its contribution.

Presently I think we are down to around 20 percent contribution from the Federal Government. Most of that has simply been we have not raised the per diem rates for nursing home care.

One problem that I raise in a question with you is what precedent our waiving the certificate of need for Denver would have on the rest of the country. We are trying to force OMB to dislodge the backlog of funds that are to be obligated for the expansion of the State home program and the certificate of need on a State-by-State basis has proven helpful in some areas in not overbedding an area or building facilities that are not warranted.

Before we could come back to you and say your suggestion is a good one and we are going to go to Washington and do it, we have to make some impact assessment as to what it would mean if we provided you with that opportunity here, what does that mean for New York City, Boston, Chicago, San Francisco? What does it mean for both urban and rural communities across the country.

Mr. GILMER. I appreciate your comment. The amendments that we are requesting gets away from the need to get a waiver for a certificate of need. We are talking about existing nursing home beds in the Denver area. We are talking about a facility that has already met the certificate of need process; the beds are already there; you don't have to go back to the certificate of need to purchase that facility.

Mr. EDGAR. You are suggesting replacing an existing facility that may be providing nursing home care and just putting vets in that facility.

Mr. GILMER. We are suggesting there are nursing homes in Denver that we are told would like to sell their facility. We are suggesting——

Mr. EDGAR. We have some in Philadelphia we will sell you.

Mr. GILMER. One of the problems is, if we cannot build them in the Denver area for the vets and we know we need them here, and there are beds, those nursing facilities can be purchased, we know we don't have to complete the certificate of need processes; we don't need a waiver—all we need is an amendment in the law that will allow that process to go into effect.

Mr. EDGAR. Suppose we magically do that. Do you know where you are on the shopping list of dollars that are already in backlog on that program throughout the Nation?

Mr. GILMER. We are fortunate in the facility that we are presently applying for that we applied for some 4 years ago, so we are being considered now for it. We understand that the backlog is something like 8 to 10 years.

So in our longer testimony we recommended that the Congress increase the amount of dollars going to that program because I think a lot of States are discouraged from applying for it because it is such a long wait. It is very difficult to get those dollars. So in the longer testimony we did ask that that be done as well.

Mr. EDGAR. Thank you.

Mr. HAMMERSCHMIDT. No, I don't have any questions, but I want to thank all of you for your very fine testimony.

Mr. EDGAR. Thank you very much. The DAV last testified at our other hearings. Your testimony will complement that record. We will make sure you get a copy of the full set of hearings.

Mr. NORMAN. Thank you.

Mr. EDGAR. Our next set of witnesses will be Ms. Brenda Van Antwerp, service officer, Department of Colorado, American Legion, accompanied by Mr. John Kovar and Mr. Pat Smith.

Mr. Kovar is adjutant, Department of Colorado, and Mr. Smith is national executive committeeman.

Welcome to our hearing. We appreciate your presence.

Your full statement will be made a part of the record. We invite you to proceed.

STATEMENT OF MS. BRENDA VAN ANTWERP, SERVICE OFFICER, DEPARTMENT OF COLORADO, THE AMERICAN LEGION, ACCOMPANIED BY JOHN KOVAR, ADJUTANT, DEPARTMENT OF COLORADO AND PAT SMITH, NATIONAL EXECUTIVE COMMITTEEMAN

Ms. VAN ANTWERP. Mr. Chairman and members of the subcommittee, on behalf of the more than 20,000 members of the American Legion, Department of Colorado, I wish to thank you for inviting us here today to express our views on Veterans' Administration health care, as represented in the Denver metropolitan area.

The American Legion would like to point out that the veterans of Colorado are very fortunate to have three Veterans' Administration medical centers. As you know, Colorado is geographically divided by the Rocky Mountains, and the fact that the VA has taken this into consideration in their past planning by placing a VAMC on the western slope, one in southern Colorado, and one here in Denver, is greatly appreciated by the veterans of this State.

This planning on the part of the VA has provided most veterans in our State access to a VAMC near their community.

I would like to now address the most obvious problem of the Denver VAMC. Because this hospital is landlocked and because the hospital is currently under construction, parking spaces are minimal. Although we expect this situation to improve after construction is completed, adequate parking is not going to be available even at that time.

There simply is no space. We would ask this subcommittee to seriously consider funding for a high rise parking lot for the Denver VAMC. While parking lots in and of themselves are not part of health care issues, we certainly feel that inadequate parking could affect health care in that aged, severely disabled, and seriously ill veterans may not be able to obtain health care simply because they will not have easy access to the hospital.

In addition, frequent and large snowfalls and temperature changes make adequate and nearby parking a necessity in this area of the country.

There are over 400,000 veterans in the State of Colorado. Approximately 60 percent of these veterans live in the Denver metropolitan area. The Denver VAMC provides health care for a large number of these veterans, and many have service-connected disabilities.

Because of the large number of service-connected veterans seeking treatment at this hospital, it is very difficult for a veteran with a non-service-connected disability, even one who meets the eligibility requirements set by Congress, to obtain outpatient treatment from our VAMC.

Also, due to the budget restraints at the State and local levels, many veterans who previously sought treatment at Denver General Hospital or the University of Colorado Medical Center are being referred to the Denver VAMC.

In turn, because of limited resources, the VAMC is unable to meet the needs of these veterans.

The American Legion is in no way suggesting that the current priority system for health care treatment be changed. However, we are concerned that as the veteran population continues to age, their numbers will further tax the resources of the VA. Inevitably, many veterans who have never used VA services will seek to do so as they get older, experience more health problems, and are forced to live on reduced and fixed incomes.

We are aware that the VA has already undertaken a number of initiatives to begin to provide care for older veterans.

For instance, ground has recently been broken for a 60-bed nursing home unit as part of our VAMC. We are supportive of these measures and would ask that this subcommittee continue to insure that the VAMC has adequate funding for these and other measures.

It is our feeling that one of the major problems at the Denver VAMC is the quality of psychiatric care.

Mr. Chairman, in May of this year, two veterans, both represented in their efforts to obtain VA benefits by the American Legion, attempted to commit suicide at the Denver VAMC. One veteran died as a result; the other veteran is now a high level quadriplegic. The deceased veteran was an outpatient at the VAMC and was evaluated within minutes prior to his death as not needing hospitalization, nor was he considered to be a danger to himself or to the community.

The second veteran was being held on a locked ward, and while in his room managed to break through a suicide prevention screen—a task that is estimated to take more than one-half hour; all without alerting anyone on the VAMC staff—and leap from the seventh floor of the hospital.

In addition, in the last few weeks, a veteran was placed in the VAMC on 180-day hold and treatment. This veteran was allowed to walk away from the VAMC and no one from the VAMC sought to locate him. His bed was held for 1 day and then he was decertified.

He subsequently murdered two members of his immediate family. These tragic deaths and serious injury raise serious questions in our minds as to the quality of care provided by the psychiatric program at the Denver VAMC.

A related problem here in Denver is the evaluation and diagnosis of posttraumatic stress disorder during disability evaluation examinations for compensation purposes.

For example, although the veteran exhibits symptoms such as recurrent dreams about being killed in Vietnam, startle response, limited social, or interpersonal relationships, the examining physician arbitrarily states there is no evidence to support a diagnosis of PTSD.

While we realize that the adjudication of PTSD claims by VA regional office rating boards is not under consideration during this hearing, there is a relationship between the disability examinations and the rating of these cases.

We feel this is a serious situation and we have developed a number of cases wherein problems concerning the diagnosis and/or rating evaluation exist. We have forwarded these cases to our national office for presentation to the proper VA officials.

In addition, through our national office we have asked that Dr. Donald Custis, Chief Medical Director, provide a medical inspector general to investigate the quality of care at this hospital.

Mr. Chairman, we respectfully request that this subcommittee require the VA to investigate these conditions. However, we do not wish to totally condemn all of the psychiatric services provided by the Denver VAMC, and with this in mind, the American Legion, Department of Colorado, would like to express our gratitude to the VA and the subcommittee for providing adequate funding in Colorado for the contract psychological counseling program for Vietnam veterans.

While the American Legion has supported the concept of the vets centers and contract care from the beginning, we in Colorado consider ourselves most fortunate in having a nationally recognized expert in PTSD, providing contract psychological care to our veterans.

We would like to commend Dr. Tom Williams and other contractors in the Denver metropolitan area for the outstanding services provided to veteran clients of the American Legion. We would also like to thank the VA for expanding the contract care program into remote and outlying areas of Colorado.

We recognize that one of the reasons for establishing vets centers and contract counseling was based on the fact that many Vietnam-era veterans objected to the administrative redtape at Federal facilities.

It is our belief that these objections will not soon subside. For this reason, and because of the excellent services received through contract care here in Colorado, we strongly urge the subcommittee to continue funding for this significant program. As a service officer, I have referred many veterans to contract care providers, and in my opinion this program has worked and worked well for my veteran clients.

This concludes my statement, Mr. Chairman. Thank you for allowing us to express our views on these issues.

[The statement of Ms. Van Antwerp appears on p. 82.]

Mr. Edgar. Thank you very much. We particularly appreciate your raising the issue of parking, which was raised also by some of the other witnesses, and one we talked about today.

As I understand it, there is a long-term solution coming somewhere in the 1989 timeframe for parking. There are a lot of parking tickets between now and then. But it is in the 6- to 7-year plan to provide a parking facility.

Some of the temporary buildings we were into today will be torn down and provide space for a parking facility, but those buildings cannot be removed until some of the renovation gets completed. So there is a little bit of chicken and egg situation.

We will go back and review that in more detail in Washington, some temporary provisions might be made.

The long-term parking facility that you are asking for will be a long-term facility coming at the end of the eighties as opposed to a more immediate need than you are expressing.

Denver is so high, I wonder how high you can put a high rise—call it the 2-mile high parking facility. I think that is a need I see you have expressed and it has been expressed by others.

Let me ask all three of you a question.

If you were to address the regional director of this region, that goes from Montana to Texas, what would be the key question you would ask of him in terms of quality of care?

And, second, if you were to address the Denver director of this hospital, what would be the key question you would want to ask of him?

Ms. **Van Antwerp.** I think the key question that I would have to ask would have to do with the quality of psychiatric care provided at this facility.

As a service officer, it has been my experience with the veterans that I represent that I have never—I won't say never—very infrequently found a veteran who is satisfied with the in-patient psychiatric care provided at the Denver facility or the out-patient care that he has received through emergency services, that type of thing.

I have yet, at least within the last year, I have seen some major problems come about as a result of compensation examinations for post-traumatic-stress disorder, and not just post-traumatic-stress disorder, but some of the other things, like the POW examinations, if they are dealing with a psychiatric disorder.

As I think I said in my testimony, that raises some real serious questions in my mind about why and how; what is going on in Denver?

Mr. **Edgar.** Do the others have questions they would ask of the regional director or the medical director?

Mr. **Smith.** Mr. Chairman, in my travels, and I have been traveling the country, probably I would have to agree with Brenda.

I am a Vietnam veteran. I do discuss quality care at the VA centers with Vietnam vets, and the psychiatric care seems to keep cropping up.

Problems such as we cannot get our prescriptions on time, and the things like the parking here. But, on the whole, I think the psychiatric problem is probably the one that has to be addressed in the future, particularly from Vietnam veterans, but also—Mr. Hammerschmidt, you alluded earlier to the World War II veterans. Essentially the problem is the same. Maybe it was not recognized back then. I think if we are going to improve the quality of psychiatric care in VA medical centers in the future, we must start addressing some of those issues coming up now.

Let me maybe as an aside or also as an addition to this, let me make one comment also about my travels.

Last year I did quite a bit of work with the State legislature. There was a brand new State senator who was a Vietnam combat vet. We were doing some work on the nursing home. His question to me at that time was, why do we need the VA medical centers? Why can't we contract these people out to a general hospital?

In my observations in the last 15 years since I have been a member of the American Legion, since I have been discharged from the service, I see that the VA's public relations image, there is very little public relations work done by the VA.

The public perception of what the VA is and what the VA medical center is and what they do is of a very low quality.

I think maybe this has been overlooked over the years past. You need, through Congress, or whatever, to educate the American people as to the quality and the reasons we need the VA medical centers. Very few people know the VA was the leader in penicillin, also prosthetic devices. There are many, many things.

In the area of contracts with other medical schools in the area—tuberculosis, another example. The public does not perceive that. They don't know the VA has advanced medicine through their system.

I think that is part of the problem we are having when it comes to funding with the administration and with Congress, and we are talking about dollars to go to veterans. We are looked at as a special interest group. That area concerns me. I think in the future there needs to be something addressed as to a public relations effort.

Mr. Harry Walters, the new Administrator, I think probably is the best PR tool they have going right now. I have been in the audience many, many times when he has spoken. He is an excellent advocate for the veteran and also a very good public relations man because he does have the facts.

Mr. **Edgar**. I would agree with you about Harry Walters being the advocate and doing a good job.

I have two other comments that I might just share with you. One is an observation, one is a comment I would like to make relating to the image of the system.

As we have traveled the system, it is interesting that in a new hospital, expanding new, in Bay Pines, Fla., morale is very high. Patient experience is very high. Every time you go into a room and put your hand on the arm of a patient, they smile back. The care is wonderful, the quality is good.

In some of the older hospitals you get a feeling in some of the units that things are pretty good, but I have seen generally across the country, particularly for the psychiatric patient in cramped quarters, in an aged facility that may be outmoded in terms of the kind of modern health sharing in facilities, a nice setting for a therapy session, a nice setting for a group experience in that setting, there is a sense of depression and a sense of downness which leads me to my observation.

I wonder if some of the immediate psychiatric problems that this hospital is facing don't only have to do with the quality and quantity of care provided inside the building, but if you are a psychiatric patient and you come to this facility and you see everything is torn up, everything is under construction, you are hassled about where to find a place to park, you get out of your car and you are trying to find which building and which piece of the building you have to go to, you are then put into a setting that was built in 1952—it is going to be replaced, and it is under a plan to be replaced, but it seems to me that in and of itself might be a psychological barrier to good health for that individual.

And, any hassle by a clerk or a staff person or a unit personnel may simply be the straw that breaks that person's mental capabilities.

I am not trying to defend, because I don't know the health care system here, so don't put me in that category.

I am just simply making an observation as an outsider coming and wondering whether or not there isn't some relationship to the building being old and torn up and the experiences that you were laying out. We will ask that of the director, so we will get some data on that.

Ms. VAN ANTWERP. I think in response to your comment, I think the condition of the hospital, with it being under construction, very well may play a part in that.

I know some of my psychiatric clients will not go to the hospital because of the current condition of it.

However, I think in the instances that I mentioned, one of them was already in the hospital on a locked ward and the other one has been a long-term care patient, and I really don't think that played a major part in it.

I think there are some real problems with what is going on inside the hospital, the quality of the care provided.

Mr. EDGAR. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Ms. Van Antwerp, we appreciate your statement, but it is the sort of a statement that worries us.

I feel a certain amount of tension and distress in it, obviously.

Let me ask you, do you feel you have good access to the management of the VA hospitals in Colorado? Are you able to communicate with them?

Ms. VAN ANTWERP. For the most part, yes.

I have had some fairly recent experiences that have opened communications and we have been dealing with a number of other issues. But, yes, we do speak.

Mr. HAMMERSCHMIDT. Those are, of course, serious allegations that you raise about the psychiatric unit, and, of course, they alarm us, coming from such a credible witness that represents a broad segment of the veterans' community.

Of course, I assure you we want to see ourselves what the facts are on that.

Has the national office had any response about an IG looking into that?

Ms. VAN ANTWERP. I talked to my National Director yesterday afternoon. He has in fact—we have raised some of the issues that I raised here today to Dr. Custis, and Dr. Custis, it is my understanding, has now responded.

However, he did not address the issue of a medical IG. He simply perhaps overlooked that in his response to us.

Mr. HAMMERSCHMIDT. Have you had the opportunity to have an eyeball-to-eyeball discussion with the management of the hospital about this?

Ms. **Van Antwerp**. No, I have not, because of my own deep involvement with the two individuals, the one individual, the one that is now deceased, was a very close client, and I think you can appreciate the fact we not only develop a good working relationship with some veterans, but also sometimes a sort of friendship with them, and consequently I found it very distressing and preferred to allow my National Director to deal with this, since it allowed him to have more objectivity than myself.

Mr. **Hammerschmidt**. Well, we apreciate very much your being here.

I might say to Mr. Smith, I know our whole committee agrees with you that the word doesn't get out in most cases about the high quality of care of the VA.

We know how important it is just not only to vets, but the entire health care, training of all the doctors in the country; it is kind of a closely held secret.

We have 172 hospitals out there. We try to spread the word. We know Harry Walters is now really trying to spread the word. And most of the stories we hear are good stories.

We don't obviously like to hear the horror stories, but when we do hear them, we want to look into them.

Mr. **Smith**. I don't think it is only Congress job to do that. It is ours as veterans, veterans organizations, to spread the word about the quality of care and about the excellent system and the excellent VA system we do have. The thing that happens, though, when I am not wearing this hat and no identification as an American Legion member and I am not on my daily job, the thing that happens is, people say $26 billion for veterans health care, and that scares them when we are looking at inflation.

Mr. **Edgar**. It is $26 billion for all of the veterans' services; $8.1 billion for hospitals.

Mr. **Smith**. $26 billion for the budget of the veterans, and they say, "Did the veterans really do that much that they should have that much coming to them?"

So it is really a hard point to sell out there.

Mr. **Hammerschmidt**. Thank you very much.

Mr. **Edgar**. The amount of money is $8.1 billion for the day-today operations. About $800 million for new construction.

You did mention the research and the creativity of the hospital system.

We have mentioned in several of cur hearings the fact that VA research has received two Nobel Prizes for its work. One of the things that kind of amuses me is that there are a lot of news stories and articles about how this research project and that research project is bad.

And some of it is justified.

The National Science Foundation and others study the sex life of a fly and people just all laugh, but one of the illustrations that I use quite often, which you mentioned, is, if I asked you for $100 million to study mold on bread, you would probably say no, but that is exactly how we discovered penicillin.

Some of the things that you hear in terms of research agendas sound obscure, but in fact might have a very legitimate research focus, and I think there has to be a balance between the headline stories, funny stories about research and specifically what is the research trying to do.

Thank you all.

Mr. EDGAR. Our next witness is Edward Glade.

STATEMENT OF EDWARD G. GLADE, SERVICE OFFICER, DEPARTMENT OF COLORADO VETERANS OF FOREIGN WARS

Mr. GLADE. Mr. Chairman, members of the committee, I thank you for the privilege of appearing before this distinguished committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Edward G. Glade, and it is my privilege to serve as State service officer for the Department of Colorado Veterans of Foreign Wars of the United States.

Mr. Chairman, the top priority of the VFW with respect to our Nation's veterans is to maintain the integrity of the vast VA hospital and medical care system.

Mr. Robert O. Wikoff, our national field representative for the western area of our great country, had intended to appear before this committee but, due to business at the Albuquerque, N. Mex. VAMC, he is unable to be present today.

He has requested that I present his views and, with your indulgence, I will present his views and the feelings of a vast number of veterans from Colorado.

STATEMENT OF ROBERT O. WIKOFF, NATIONAL FIELD REPRESENTATIVE, VETERANS OF FOREIGN WARS

Mr. Chairman and members of the committee, my name is Robert O. Wikoff. I have been employed by the Veterans of Foreign Wars of the United States for over 36 years. During this period of time, I have seen the VA medical programs in operation almost on a daily basis. Not only have I been an advocate of the veterans seeking medical attention, but I have been a patient at VA medical Centers.

When the VA started their affiliations with medical schools, they had a residency training program, the preceptor of the resident as a full-time staff physician, board-certified in his field. The resident spent 1, 2, or 3 yeas in a residency training program.

This was ideal in that when the ward physician or the resident called the veteran back on the old completion of bed occupancy care, either the ward physician or the resident saw the veteran. It was not like today where the VAMCs have one-eighth or seven-eighth time physicians who also are to spend a like number of hours at the medical school, and the students, 4-year interns and residents, rotate through the VAMC all the way from 6 weeks to 6 months.

Many times when the veteran is requested to return for followup care, the physician who requested it is no longer at the VA medical center. This causes confusion on the part of the veteran as well as the physician who is to treat the veteran. I feel the VA would be much better off if they would go back to the old residency training program; have full-time staff physicians and 1-, 2-, and 3-year residents.

VA medical budget is based upon inpatient average, daily census, and visits to the outpatient clinics. Here again, I speak as a former inpatient and outpatient. Inpatient care I have found to be excellent and the time I spent in the medical center was needed. However, the outpatient program needs streamlining. There are far too many return visits in many cases. I feel they could treat far more patients on an inpatient and outpatient basis by not scheduling the same veteran to the same clinic so many times.

It is necessary for VA Central Office to obtain the blessing of the dean of the medical school before a director, associate director, or a chief of staff can be appointed to a VA medical center where there is a full affiliation with the medical school involved. By receiving the blessing of the dean, this only means that whatever the dean of the medical school wants, the director, associate director, or chief of staff must comply with.

At the dean's committee meetings, the director, associate director, and chief of staff are members without voting privileges. This should be changed and the VA representatives have an equal vote on matters involving the operation of the medical center.

In conclusion, Mr. Chairman, thank you for having held this oversight hearing.

Mr. **Edgar**. Thank you very much. I hope you will tell Robert Wikoff that we did miss his presence, but we appreciated him allowing you to read his statement. You do cover some areas that were not covered by previous witnesses. I appreciate that.

I wonder if you might just respond to a simple question about the distances involved in this particular medical district. Have you had any complaints from your veterans about the long distances that they have to travel in relation to outpatient visits?

Mr. **Glade**. We have many responses on that.

As you know, the mountains here present quite a problem for many veterans that have to come in here. It makes it awfully hard for some of the veterans from the southern part of the State and the mountain sections of the State to get to the medical center, especially during the winter months.

Already the snows are falling in the mountains, making travel hazardous.

Mr. **Edgar**. Thank you.

John Paul?

Mr. **Hammerschmidt**. Thank you, Mr. Glade. We appreciate your testimony, and Mr. Wikoff's statement.

Let me ask you, do you feel that you have good access to the management of the VA Hospital in Colorado?

Mr. **Glade**. I have been a service officer here in Colorado 12 years. Especially in the last few years I have found an open door policy and I have no problems in presenting a problem to the director, associate director, or the chief of staff.

I also have access to medical administration, where we have very good rapport with them.

Mr. **Hammerschmidt**. We appreciate very much this major point that Mr. Wikoff made about medical affiliations of the schools with the VA. We know that is a major policy decision and one that we are interested in.

Let me ask you about other matters. Do you hear any criticisms or comments, for instance, about physical examinations in the hospitals, agent orange, radiation exposure, prisoners of war?

Mr. **Glade**. The main complaint that we get is that it is just a cursory examination, very limited. The doctor just asks a few questions, and then the veteran is turned loose. Veterans feel that they deserve more and should be getting more.

Mr. **Hammerschmidt**. Do the pharmacies seem to be operating on a timely basis? Do you hear many complaints?

Mr. **Glade**. The pharmacy has been having problems. We viewed the new computer system they have. I think this will correct some of their problems. Here again, if we have any problems with the delay in prescriptions arriving, we have a very diligent lady taking care of the phone calls, and she gets those prescriptions out. I have not been having much problem with this.

Mr. **Hammerschmidt**. Thank you very much. We appreciate service officers, because we know what your job is.

Mr. **Glade**. I spend every Wednesday out at the hospital visiting the patients and listening for complaints, and getting them to the proper people. And Sunday mornings I spend out there as a volunteer.

Mr. **Hammerschmidt**. We say everywhere we go, because it is true, these hospitals could not operate without volunteers. Thank you very much.

Mr. **Edgar**. One of the things I might mention before you leave, and I mention this to you and to all of the service officers who testified as well as the veterans' organizations that testified, in our effort to analyze the future of the veterans system, we are really looking for some innovation.

I think it would be helpful if you could go back to your organization and the other organizations here and have some workshops and some study groups talk about ways in which we can improve the quality of veterans' health care in the future, given the pressure of the aging veteran and some of the other problems.

We are really serious about that innovation. The major veterans' organizations have been a strong opponent, particularly in Washington, of what is called mainstreaming; that is, putting the veteran in the main course of health care in the private sector. There is an emerging aspect that deals with sharing of resources.

For example, a rural community hospital might have a mini-veterans clinic associated next to it so that the veterans could go and get some preliminary care at a smaller outreach clinic, use the technical resources of the community hospital, and then for acute care needs would be serviced in the traditional way in a veterans' health care network. That kind of shared relationship would save an awful lot of money into the future.

Some of the veterans' organizations testified of the value of State-Federal relationships in providing nursing homes, and if that program were increased, how many more veterans would be cared for. That is also an economical way for us to care for that problem.

It is estimated our budget is going to be $100 billion in deficit next year, as it was last year, and the foreseeable future, in order to buy the defense that Congress and the President have committed themselves to, and to give the tax breaks that Congress and the President have committed themselves to, and squeeze some of the domestic budgets where they can. There may be more veterans needing health care than we have the resources to provide. So I would give a challenge to all of the veterans' organizations to give some consideration to that broader view, the 5-, 10-, 20-year planning view for veteran needs.

Thank you for your testimony.

Mr. **Glade**. Thank you.

Mr. **Edgar**. Our next witness will be Mr. Robert Stewart, who is a contractor, veterans' readjustment counseling program.

We are pleased to have you here today. We look forward to your statement. The full text of your statement will be made a part of the record.

STATEMENT OF ROBERT W. STEWART, CONTRACTOR, VETERANS' READJUSTMENT COUNSELING PROGRAM

Mr. STEWART. Thank you.

I would like to review the brief summary that I submitted and expand briefly on portions of it.

As you mentioned, I am a contract provider of readjustment counseling services to Vietnam-era veterans. The program I am associated with, the Nam-Vet counseling program, opened full-time offices in Greeley, Colo., in April of this year, and last month we opened a part-time office in Fort Morgan, serving Morgan County.

In our program we have four therapists providing services, not only to Vietnam-era veterans, but to their significant others through individual, couple, and group counseling.

Our staff consists of two licensed psychologists, another psychologist who is a candidate for licensure, and a master's level counselor specializing in drug and alcohol counseling.

I am a Vietnam veteran as well as a licensed psychologist. The other three therapists are female therapists who are nonveterans. The major advantage that gives us is being able to provide veteran-nonveteran and male-female therapy teams to work with couples, families, and to do group therapy.

The population we serve according to the Colorado Veterans' Affairs Office: Weld County has approximately 5,290 Vietnam-era veterans; Larimer County has 5,500; Morgan County, 850; and Logan County, 910.

The need for services in the rural areas is great, partly because one of the factors that is prevalent in Vietnam-era veterans suffering from post-traumatic stress disorder is alienation and isolation. So they often are drawn to more rural areas or smaller towns to avoid contact with large populations.

As has already been mentioned, one of the difficulties, of course, is long distances. It is 50 miles from Greeley to Fort Morgan where we have one of our offices. It is another 50 miles beyond that to Sterling, where we are not providing services yet. We would like to open a part-time office in Sterling perhaps in the future. We are serving this area partly by my being able to travel that far—I am a pilot, and I part of the time drive and part of the time fly to Fort Morgan. I could do that to Sterling.

The program workload we have experinced so far in the few months we have been operating—we contracted to provide up to 32 sessions per week of individual counseling, and up to 3 sessions per week of group counseling. We were providing about 40 percent of the maximum individual sessions by August, and expect to be providing 75 to 80 percent of the maximum by the end of this month.

In addition, we will be providing two groups for Vietnam veterans or for partners of veterans.

The number of individual sessions that we have provided has grown very rapidly. It doubled in the first 4 months of service and it doubled again in the last 2 months. We currently have approximately 35 clients who are actively involved in counseling and we project that we will be providing the maximum number that we contracted for by the end of this calendar year.

Also in our area, the Cheyenne Veterans Center has a full-time staff member in Fort Collins, and he works not only in Fort Collins, but the Greeley area also. His workload matches or exceeds ours. So there is, I think, a strong need for a satellite center in the Fort Collins-Greeley area, and perhaps other cities like that.

Part of the rapid growth in the services that we have provided has been in spite of some desire to progress somewhat slowly in the beginning, so that we could be assured of providing quality services while we are becoming established, we now—one of the things that would help at this point would be some additional freedom in publicizing our program directly to veterans. There is some confusion in the contract about what amount of publicity we can give. We have made a lot of contacts with other service providers, but have been told that we are not allowed to publicize the availability of the program, for example, on public service announcements.

The effectiveness of our program—it is a very effective and efficient program. It and the other services offered through the Denver and the Cheyenne Outreach Veteran Centers are the only outpatient services that most of the veterans that I have contact with in our area will use readily. VA hospital outpatient services are often avoided because of the inconvenience of distance, and many of the things that have already been mentioned—the crowding of the facility and so on; and also, particularly it seems like in the minds of Vietnam-era veterans, an association with bureaucracy and with Government generally.

There is a lot of antipathy among the Vietnam-era veterans for Government and large agencies. They don't see the veteran centers in that same light nor the contract providers. So I think it is an excellent mode of reaching veterans.

Mental health centers are often avoided by veterans because they are perceived as not very sensitive to Vietnam veteran issues.

Often the staffs of mental health centers either do not have veterans or the staff members are not well-aquainted with those issues. That has not been necessarily the case in Greeley. But even when there are veterans' services offered, there is always a stigma of mental health that all of us in that profession have to deal with. It is particularly true I think in mental health centers. Two of the hallmarks of Vietnam-era veterans having problems are alienation and withdrawal into isolation. I think that population especially requires convenient community services that they perceive as responsive to their needs.

During our 8 months of service we have helped veterans gain and maintain employment, prevent incidents of violence, we have helped them abstain from alcohol and other drug abuse. We have reduced marital discord and family breakup. We have helped them obtain emergency hospitalization and inpatient treatment when that was necessary, and have helped them decrease anxiety, flashbacks, nightmares, insomnia, and so forth.

We have heard almost unanimous appreciation for our program, not only from veterans, but from other helping agencies in the community.

In summary, I think just to restate, the Vietnam-era veterans tend to be rather cautious and I think at this point suspicious at times as a population. It is very important that they perceive service providers as respecting them as veterans. Those most in need are often hard to reach, and that may be one reason being able to publicize more directly would be helpful.

One of the things we have attempted to do also is to make a special appeal to agencies that contain female veterans, because that is a population that has not been reached much at all. Many of them are equally in need of service as the males are.

Thank you.

[The statement of Mr. Stewart appears on p. 85.]

Mr. EDGAR. Thank you very much for your statement.

I just have a couple of very quick questions for you.

Who is your point of contact within the VA? Who is your contracting person?

Mr. STEWART. The person I actually work with on a day-to-day basis, the Denver Veterans Center, Mike Pantaleo and other staff.

Mr. EDGAR. Do you have an ongoing training program for your staff in terms of emerging Vietnam-era veterans' problems and how to approach them, deal with them, a sharing with other staffs in the area, workshops, seminars, that type of thing?

Mr. STEWART. Yes. We have had some brief workshops that I have set up for people, for my own staff. We plan to do more of that as they become available locally. And we also do educational programs in the community for other agencies. We have one scheduled, for example, in about a month for the school district, to talk to the school psychologists, social workers and so on, who often have contact with children who may be in an abusive family or suffering other problems because one of their parents is a Vietnam-veteran.

Mr. EDGAR. We are real pleased with the concept of storefront or out of regular settings for counseling for Vietnam-era veterans and other veterans who have particular problems, and who cannot have access to the traditional settings. That is why we have been strong advocates of the readjustment counseling center program.

I guess my question is a tough one. Our contract services are hot and cold. We have some very good ones, and we have some very bad ones. We have some good ones that are providing good service to the veterans, who understand the unique problems of Vietnam veterans. But as with any kind of contractual situation, the ability to maintain the quality of that care and to monitor the quality of that care has been a little bit limited.

I wonder if you have any suggestions on how we can be assured in Washington as we have to vote on the availability of contract services, particularly for rural areas, how to maintain the quality control on the services provided—that is the technical services, the individual counseling services, the group therapy services, that they in fact are not somebody's half-baked idea of how you respond to Vietnam-era veterans, such as psychics meeting around a crystal ball, eyeball, but are in fact real therapy sessions with some real value.

Do you have any suggestions on how we might do that?

Mr. STEWART. Well, I don't have any briliant ideas right off the top of my head. I guess one of the best contacts perhaps through the veterans centers would be feedback from the veterans themselves.

Mr. **Edgar**. You can do that institutionally within the settings that we set up. I am talking on future expertise, I have some reason to believe you are doing a good job with your service. But you have three persons on staff, none of whom have served in Vietnam.

On a day-to-day basis you are visiting with Vietnam veterans who may have flashbacks or other problems related to delayed stress syndrome. If we are going to zero in on that particular problem, how do we go out to your veterans or out to your staff and monitor the quality of their services?

Do we just take it on faith? How do we know it is working?

Mr. **Stewart**. I really don't know what the answer to that is.

One of the things that makes it very difficult is in my profession confidentiality is rather important, and that really puts a block to identifying clients and getting that kind of feedback. I can institute some of that at my level with my own staff, but you still would have basically my word to go on.

Mr. **Edgar**. I guess that is why I was asking who is in a sense your contact person, because it seems to me that there is a need for contract services in areas where we can't establish a full setting. But that contractor service ought to be closely associated with the 135 official readjustment counseling centers we have put in place, or the ones that are manned by VA personnel. Not that they are necessarily better or worse, but it gives us a line of contact.

And secondly, it seems to me that all of you have an enormous amount of information to share with each other about the type of cases you are dealing with, the kind of situations you are getting into, hostage situations where veterans have had problems, as was related earlier the problem of suicide, attempted suicide of psychiatric patients, the kind of unusual problems we face.

We have had the good opportunity of visiting two combat units inside the Chicago facility and one in Florida that have 10, 12, 20 veterans in a special psychiatric unit for a 6-month in-house psychiatric setting, but also a setting on how to get back into society. We have had the opportunity to go out to the veteran centers and see the quality of care that is given.

We have had some rap sessions with the staff, but also with the veterans who have been helped, serviced by those centers. So we have a feel in that way.

I guess our concern is we have to go back to Washington and convince the other Members of the House and the Senate that the contract care service in rural areas or in remote areas is important, and its quality is going to remain high because of—and when we get to that "because of" it is very tough to come up with reasons to justify it.

You may want to think about that and reply for the record.

Mr. **Stewart**. It is very difficult to be able to assure that. I can tell you some of the things I am involved in, in maintaining contact—we are in an unusual geographic area. Although our contract is with the Denver Center, the Cheyenne Center is the one that staffs our area. I maintain very close contact with people in that area, exchange information, talk about situations we are having difficulty with.

Tomorrow I am flying to Chicago for the second annual post-traumatic-stress disorder conference. DAV has an excellent in-service training program that we are going to arrange in our area for our staff as well as other community professionals.

I think much of it is perhaps checking on whether a person is continuing some contact and education in that area.

Until I got involved in this contract, I did not have a lot of knowledge specifically about post-traumatic-stress disorder, although I am a Vietnam veteran. But one of my specialties is stress management, I'm certified as a biofeedback therapist. So the relationship is close.

That obviously only applies to me. I don't know how on a global basis—I don't have a good answer for your question.

Mr. **Edgar**. I sure wish you would come to Washington to help us with stress management. We had a consultant come into my office personally. We had a full day session both at the district office and my Washington office on stress management. We are now buying ice cream occasionally and sitting down and eating ice cream and doing other types of tension relievers.

John Paul?

Mr. **Hammerschmidt**. Thank you, Mr. Stewart, for your testimony.

As I understand it, you have a contract on four rural counties basically?

Mr. **Stewart**. The contract specifies the Greeley-Fort Collins area. It actually doesn't specify by counties. But there is no other contractor northeast of Boulder and Denver.

Mr. **Hammerschmidt**. You feel there are a little over 12,000 Vietnam veterans in that area?

Mr. **Stewart**. Right.

Mr. **Hammerschmidt**. You are a Vietnam veteran?

Mr. **Stewart**. Yes.

Mr. **Hammerschmidt**. Did you serve in Vietnam?

Mr. **Stewart**. Yes, I was a helicopter pilot.

Mr. **Hammerschmidt**. What is the price tag of your contract?

Mr. **Stewart**. I am not sure exactly. If we were operating at full capacity for a full year, I think it was 90-some thousand.

Mr. **Hammerschmidt**. Per year?

Mr. **Stewart**. Right.

Mr. **Hammerschmidt**. Is your contract for 4 years?

Mr. **Stewart**. No; it is on a 1-year basis.

Mr. **Hammerschmidt**. And you have been in operation 6 months?

Mr. **Stewart**. Right.

Mr. **Hammerschmidt**. And after the first 2 months or 4 months, the number of veterans have doubled and then redoubled?

Mr. **Stewart**. Right.

Mr. **Hammerschmidt**. In 2 more months—how many veterans is that?

Mr. **Stewart**. The total number of veterans we have seen is between 50 and 60. The number of clients would be greater than that, because we also work with family members.

Mr. **Hammerschmidt**. Do you keep a case log on these activities for these veterans?

Mr. **Stewart**. Yes, we have—we keep clinical records on the counseling that is done. Each therapist keeps that. We, of course, have—each session we have to keep track of, not only for billing purposes, because we are paid on a per session basis, but we also file statistical reports at Fort Snelling.

Mr. **Hammerschmidt**. In your statement you say during the 6 months of service:

> We have helped veterans gain and maintain employment, prevent incidence of violence, abstain from alcohol and other drugs, reduce marital discord and family break-ups, obtain emergency hospitalization, inpatient treatment, and decreased anxiety, flash-backs, nightmares, insomnia, et cetera.

Do you keep the type record that if an inspector general came in that he could follow through and see what those type activities were?

Mr. **Stewart**. If the clinical records were considered open to that person—the records that now contain that information would be clinical records.

Mr. **Hammerschmidt**. But you do have that information. Of course, it would be subject to the Privacy Act. The reason I am asking you is that we don't really know for sure the effectiveness of the outreach centers. We all have our own ideas. We think they are a good supporting system, but now we are getting to the point where we are really going to have to take a good close look and see what the people are getting for their dollars.

You are a fairly new contract service. Within this legislation that we are getting ready to pass, that they have agreed to in the Senate, there is a study, and that is going to be I hope a very indepth look at the outreach centers and the effectiveness of them. So that is why I raise these questions.

Let me ask one other question.

Do you receive referrals from hospitals to your center?

Mr. **Stewart**. From VA hospitals?

Mr. **Hammerschmidt**. VA hospitals.

Mr. **Stewart**. I have not. I have received one referral from a facility in southern Colorado, a person moving to the Greeley area.

Mr. **Hammerschmidt**. Do you have a good relationship with the hospitals?

Mr. **Stewart**. In the number of months that I have been working, it hasn't been a very close relationship because the need has not been there.

Mr. **Hammerschmidt**. Of course, physically you are somewhat removed from their area.

Mr. **Stewart**. That is right. But the contact I have had with the hospital, I have had no difficulty.

Mr. **Hammerschmidt**. Thank you, Mr. Stewart.

Mr. **Edgar**. Have you referred any veterans to the VA facilities?

Mr. **Stewart**. Yes; we have used particularly the Cheyenne Hospital and the one at Sheridan, primarily for alcohol and drug crisis situations. I had one veteran that was really in a state of imminent violence. Veterans talk a lot about violence, but this person in my office had me convinced that he was ready to blow, and I was instrumental in getting him hospitalized, and he is doing quite well now.

So that is the kind of situation that we would use hospitalization for.

Mr. **Edgar**. I have additional questions, but time is running away from us. We are committed to an extension of readjustment counseling centers and contractor care service. It is just important to give you the message that we sometimes are having a tough time selling that back in Washington. So it is critical that the kinds of experiences you are going off to in Chicago really be focused on in terms of helping your staff to understand the implications, the uniqueness of what we are doing.

Also, I am going to look into the publicizing aspects of your contract, because it seems to me it doesn't make very much sense for us to have services provided and yet limit the way in which those services can be put out there.

I think I know why that was put in the contract, because that can be abused as well.

Thank you for taking the time today and coming.

Mr. **Stewart**. Thank you.

Mr. **Edgar**. We want to thank all of our witnesses who have come up to this point for their presentations.

Mr. **Edgar**. We are now going to move to a panel of people from the VA. It is time to zero in particularly on some of the questions raised. We deliberately scheduled this hearing the way it has been provided.

In some of the other hearings the VA and the VA directors have gone first and then we heard from service officers or from people with special needs. We decided to reverse it this time so some of the concerns could be raised first and that might sharpen some of our questions. Because we have had a full tour of the facility earlier and a discussion and briefing earlier by some of the VA staff, it will not be as necessary to go through all of those details once again. They can be provided for the record.

[The VA subsequently supplied the following information:]

Veterans' Administration,
Midwestern Region,
Omaha, Nebr., November 4, 1983.

Hon. Bob Edgar,
Rayburn House Office Building, Washington, D.C.

Dear Mr. Edgar: As a follow-up to the Congressional Hearing held in Denver, Colorado at the VA Medical Center on October 22, 1983, I am pleased to respond to statements presented by Mr. Glade of the Veterans of Foreign Wars in Mr. Wikoff's behalf.

All of us are aware of the triple mission undertaken by the Department of Medicine and Surgery—that of patient care; health professional education; and clinical research. No one has any argument in the VA that the first and most important of these tasks is that of patient care. We must acknowledge however, that clinical education and research help us considerably in improving the quality of care at each of our affiliated medical centers.

In direct response to the recommendations presented by Mr. Glade and Mr. Wikoff, I'm sure you are aware that the Department of Medicine and Surgery originally entered into affiliations with medical schools in order to upgrade the quality of staff and to improve the academic stimuli that results from practicing in a teaching environment. From those days in the mid-1950's, to now, 30 years later, the methods and standards for conducting medical education have undergone radical change. The teaching curriculum and rotations evident today in VA medical centers is the same as found in university hospitals, county hospitals, city hospitals, and in private health care institutions. We believe that veteran patients receive extremely high quality medical care in affiliated institutions since to provide less than that quality in a teaching environment would seem to question the quality.

In Mr. Wikoff's first statement he makes comment about the rapid rotation of residents and other house staff through our medical centers during their academic rotation. Most rotations of residents within the VA system are three to six months duration. It is true that the rotation of these residents may have a tendency to reduce the continuity of care for an individual patient. However this problem is addressed by assigning a full-time staff physician as Attending Physician on a service where residents rotate through the service as part of their training. The Attending Physician provides the continuity of care needed by the patient. This is not significantly different than what a non-veteran would find in the private health care system. As you so well know, this is the age of specialization within health care. It is not unusual for a person seeking health care to be seen by several physicians during his course of treatment. Each of these physicians would normally be specialized in some particular area of health care. Each patient admitted to a VA medical center is told who his Attending Physician is and that he may, at any time, discuss his health condition with that Attending Physician in addition to his resident physician. And of course, the Chiefs of services in our VA medical centers are generally full or substantially full-time staff members of the medical center. The Chief of Staff is always a full-time staff physician and is also available to any patient who requires additional information on his health care status. We recognize the difficulties encountered in having a rotation of house staff through our VA medical centers. However, as mentioned above, the benefit we gain from such an affiliation far outweighs the inconvenience generally to staff and patients. The continuity of health care is maintained by the Attending Physician, the Chief of Service, and Chief of Staff within each of our medical centers.

Mr. Wikoff then comments on the VA budget as based on patient average daily census and visits to our outpatient clinics. In the past, VA budgets have been built on workloads and statistical information concerning daily census, length of stay, and visits to outpatient clinics. We are currently moving away from the use of statistical information on workloads as a basis for formulating our budget plans. In the future, we will use a case mix or diagnostic related group (DRG) method of determinging allocation of resources to facilities. The methodology will be similar to that being used by the Health and Human Services Administration (HHS) in allocating funds for Medicare to the private sector hospitals. This methodology will recognize the severity of illness of a patient and the cost in delivering care for that type of disease entity. Funding will be based on discharge diagnosis of patients and a weighted work unit value established for each discharge diagnosis within a medical center. This type of funding mechanism will allow us to relate more accurately to the needs of the medical center to support the complexity of workload which they must deliver.

Mr. Wikoff comments on his observation that there are too many return outpatient visits per patient to our medical centers. Throughout the Midwestern Region, we have asked each medical center director to request a review of the utilization of outpatient care by the Quality Assurance Committee to determine if patients are receiving too much outpatient care or return for too many visits. It is obvious to each Director that he must live within his budget requirements and one of the ways to reduce the cost of outpatient care is to limit the number of visits per patient to the medical center. The decision to limit the number of visits is with the physician based on that physician's observations of the need for outpatient care for the veteran. We will not allow resource constraints to determine the type or quantity of medical service provided to veterans. A clinical decision will determine the extent of outpatient care to be provided to each veteran.

Mr. Wikoff then observes that VA Central Office must obtain the "blessing" of the Dean of the Medical School before a Director, Associate Director, or, a Chief of Staff can be appointed to a VA Medical Center where there is a full affiliation with the Medical School. In response to that observation, our Medical Center Directors are appointed by the Administrator of Veterans Affairs based on recommendations made by the Chief Medical Director and his associates. Before the selection of a Director is confirmed by the Administrator, the candidate for the position is encouraged to meet with the Dean of the Medical School as a courtesy and to gain insight by both parties into the philosophical approach which each has towards the delivery of medical care at the VA medical center. The decision on the Directorship appointment is with the Administrator of Veterans Affairs and not with the Medical School Dean. The same process applies to the Chief of Staff appointment at each VA medical center. The Associate Director appointments are made by the Administrator of Veterans Affairs with no consultation or contact with the Medical School since that position normally does not have any contact with the Medical School.

Lastly on this subject, Mr. Wikoff questions why the members of the VA management staff are members without voting privileges on the Deans Committee. A Deans Committee is an Advisory Committee to the Medical Center Director. A Medical Center Director has complete autonomy within the VA to accept or reject the Committee's recommendations. Many times those members of the Deans Committee present who have VA employment affiliation far outnumber those without this employment status. Most Directors like to attend the Deans Committee meetings to give instant feedback as to the acceptability of the Committees proposals. The Deans Committee at VA Medical Centers has as much power as the Director wishes to give it. In a situation where there might be disagreement, the Director makes the final decision which is binding on the medical center and the affiliation. The responsibility for the medical center is with the Director and the authority matches that responsibility.

We appreciate the comments of Mr. Glade and Mr. Wikoff and the Veterans of Foreign Wars concerning the operations of our VA Medical Centers. The relationship which we have with the Veterans of Foreign Wars over the years has been excellent. They have provided us with much useful information concerning the needs of our facilities and where we may improve in the delivery of care to veterans. I plan to send a copy of this response to both Mr. Glade and Mr. Wikoff and to personally thank them for their participation in the Denver Hearings.

Thank you for the opportunity of commenting on these issues.

Sincerely,

T. P. MULLON,
Regional Director, Midwestern Region.

Mr. EDGAR. Let me invite to the table Mr. Thomas Mullon, director of the Midwestern region, Department of Medicine and Surgery, Veterans' Administration, and he is accompanied by Mr. Smith, Mr. Freer, Mr. Beck, Mr. Fitts, and Mr. Lindsey.

STATEMENT OF THOMAS P. MULLON, DIRECTOR, MIDWESTERN REGION, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY CARLTON SMITH, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, DENVER, COLO.; WILLIAM FREER, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, GRAND JUNCTION, COLO.; CHARLES BECK, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER AND REGIONAL OFFICE, CHEYENNE, WYO.; JONATHAN FITTS, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, FORT LYON, COLO.; AND ROBERT LINDSEY, DIRECTOR, MEDICAL DISTRICT 24 AND DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, SALT LAKE CITY, UTAH

Mr. EDGAR. Gentlemen, your full statements will be made a part of the record and the record will be open for you to provide any additional comment you might want to make for the record. There have been a number of questions raised. Mr. Smith has been put on the spot a little bit. I think we will hear from him a little more than from some of our other hospital directors, but we do have a good representation on our panel. We really appreciate all of you coming. When I move to hear your statements, if you will introduce yourself.

We are going to start with Thomas and his statement.

STATEMENT OF THOMAS P. MULLON

Mr. MULLON. Thank you, Mr. Chairman, Mr. Hammerschmidt, and all the distinguished guests we have here today.

We appreciate your coming here today. We also appreciate the comments that the service organizations have made. I would like to compliment you on the format of the program, because I think each of us learned a great deal from the comments of the service organizations and from some of the key witnesses that preceded us and perhaps we can make some comments in that regard as we go through our presentations and I am sure you have questions for us.

I will deviate from my prepared statement, which is available to you, and just cover a couple of items very briefly in the statement that I think are perhaps of some significance.

Before I do that, I would like to introduce one person who I think is very key to this district, this district being the largest medical district in the United States, and that person is the medical district director, Mr. Robert Lindsey, who is also the director of the Veterans' Administration Medical Center in Salt Lake City. Bob arrived here a few minutes ago. He sits second from me on the right. He is very key to the local planning process for our medical district 24 and has developed the plans which you have seen and a lot of the information which has been provided to you in the statement which I have for you.

I would like to just mention that along with being the largest medical district in the United States, it is also one of the larger from the facilities standpoint. It has two of the larger facilities as well as the smallest facility of any medical district. The smallest is Miles City, Mont. Those representatives are not here with us today, but it just gives you an idea of the scope of problems that we can run into in a large medical area.

In trying to meet those needs, the medical district, through its planning process, has planned over the next few years to begin initiatives which will meet the needs of the aging veteran, and these initiatives include a plan to increase the number of VA nursing home care beds—up to 502, from 192, which is the present level; also, to increase the use of contract nursing home care by 56 percent by 1990; and to increase the State nursing home census by 93 percent, and also to establish a 60-bed domiciliary which is an extended care program at Salt Lake City. All of these facilities help us in some ways in delivering quality care for the aging veteran.

But along with that, we are looking at other options. The delivery of hospital-based home care in a rural environment is certainly a part of our planning process. We are also talking about how we may involve the service organizations in assisting us in the communities, some of these communities are located long distances from our medical centers, in helping us keep the veterans in their homes, but not in any way infringe on the quality of care that they need. The service organizations will help us tremendously in this regard by just making contacts with veterans in their homes, in their local health care institutions or wherever they may be.

We are going to expand our outreach to these rural communities. We cannot do it with the Veterans' Administration staff that we have. We are going to need the help of volunteers, of everybody who has some interest in the care of veterans.

We have tried this in several areas of the Midwest. It has been very successful in helping our aging veterans. And it is in some ways really the community interest with the VA and the cooperation between the VA and the community, and in so doing, we are able to keep the aging veteran out of a medical center which is usually a long distance from his home.

So there are all kinds of modalities and new ideas we are trying to develop. We ask the service organizations and others to help us in this regard by being a part of our planning process, our medical district initiated planning process.

We have also, as indicated in the report, or in the statement, tried to develop any number of different modalities for delivery of outpatient care in the Midwest. One of these is the delivery of the tertiary medical care through an outreach program. The program is out of VAMC Salt Lake City, where teams of highly competent specialists travel to our medical center in Fort Harrison, Mont., and also Grand Junction, Colo. They provide specialty clinics at these small medical centers and provide for the unaffiliated medical center the highest quality in the way of expertise as sent to them from Salt Lake and from, in some cases, Denver. VAMC Denver has such a program going down to VAMC Fort Lyon, Colo., for psychiatry services.

There is another method or means of doing this, and that is through the use of mobile outreach clinics. We have, as has been mentioned to you earlier today, developed mobile van programs where a team of three professionals will travel to small towns and visit with veterans in their community. We do this with the help of the American Legion, VFW, DAV, in that they let us use their halls for shelter. This has been quite effective. We have saved in our, beneficiary travel cost during the past year considerably in this regard. But more importantly, it has eliminated the need for the aging and infirm veteran having to travel long distances to these medical centers. We intend to expand these programs considerably throughout the Midwest. We are quite proud of them. And we encourage the thoughts of others in how well they provide care to the veteran, particularly, not so much to us.

These are some of the items that we had to discuss with you today from our prepared statement. If you wish, we will open it to your questions or make comments directly to you on some of the items brought up by the service organizations.

[The statement of Mr. Mullon appears on p. 87.]

Mr. **Edgar**. Before we move to the items by the service organizations, in deference to the fact that we have had a pretty good conversation with Mr. Smith, I wonder if we might go to Mr. Freer and then Mr. Fitts and just allow you to have a moment or two to react and respond and perhaps tell us a little bit about your work.

STATEMENT OF WILLIAM FREER

Mr. **Freer**. Thank you, Mr. Chairman, Mr. Hammerschmidt. I am very happy to be here. We are one of the smaller hospitals in the VA medical system.

Mr. **Edgar**. Would you identify yourself.

Mr. **Freer**. I am William Freer, the Director of the Veterans' Administration Medical Center in Grand Junction, Colo. As director of one of the smaller hospitals, we nevertheless have one of the larger geographical areas to cover. We are 250 miles from Denver, with two large mountain passes and about 300 miles from Salt Lake City. Nevertheless, we have 35,000 veterans living on the western slope of Colorado.

While we are one of the smaller VA medical centers, we are still the second largest health care delivery system on the entire western slope. We are in fact the only resource they have outside of traveling up to 500 miles to go to a large tertiary center. The area that Mr. Mullon touched upon, to give you an example, when we contracted out for some cataract surgery, it was costing us a lot of money to have the veteran go to the local contract ophthalmology for surgery. They would not follow up in areas where surgery was done at a large tertiary center. Therefore, we started an ophthalmology clinic where now the specialists come over, the surgery is done in Salt Lake VAMC and, they can follow it up in Grand Junction. This has been, I think, a very novel approach where we can take patients in our facility without them having to travel a long distance or pay out a large sum of money to local contracts.

In addition to that, we have worked very hard to set up some of the residential community facilities for veterans who live in a residential area, residential home, until such time where they may need more extensive hospital care.

Our facility is one that has been recognized, I think, by the staff there for the great compassionate care they give to the veterans. We are in an area where we do have rather a good rapport with the medical community, Mr. Chairman, and we also have a large number of nursing and medical doctors in the community where we have been able to recruit and find that we can staff our hospital with board-certified specialists.

I think we are very fortunate in having top-quality people in our small hospital. And in that aspect, we are able to take care of the veteran that does come to our hospital.

Mr. **Edgar**. What are the two or three things that would be helpful in improving the quality of care at your small institution?

Mr. **Freer**. I think one of the more difficult parts—I have worked in a 1,400-bed facility and a 1,000-bed facility before coming to a small one—is the fact that in spite of the fact that we take care of a large number of veterans, and the growth has increased rather rapidly, is that the staffing does not seem to be commensurate in some of the smaller facilities. We just don't have the people that we need, especially in some of the more technical fields like in radiology, nuclear medicine, our registered record librarians, and so forth, to keep up the data.

In the smaller hospital, the grade structure is not there to recruit at that grade level. And it is very difficult to get people that have the technical skills to come to the hospital.

As far as nurses or doctors, we are able to do very well in that aspect. But getting people that have technical skills to come in, the grade structure is so low in a small hospital that it is just extremely difficult to recruit at that level.

Mr. **Hammerschmidt**. If the chairman would yield—is there much the VA can do about that? That is just the nature of rural areas, isn't it?

Mr. **Freer**. Yes, I think there is, Mr. Hammerschmidt. I think if we took a stronger look at getting some of these specialties under the title 38 where we could look at recruitment and the qualifications of people.

Let me give you an example.

We have in respiratory therapy, a person who is highly qualified. The standard is about 10 years old. It has made no consideration for the technological advances that this person is now asked to perform. And when we go to the Office of Personnel Management and say, "Look, your standard is about 10 years old on this," they say, "Well, that is the way it is, and the standard calls for this type of a grade."

I feel that our own people, classification people, could do a much better job because they are more attuned to the medical skills that the people need to do the job.

Mr. **Edgar**. That is an enormously important statement about changes in the kind of technology, and the standards that might be made from the Office of Personnel Management—it just seems incredible to me they would not try to meet the standards with technology and try to get the upgradings that are necessary.

Mr. **Hammerschmidt**. Would the chairman yield again.

I know all of you can appreciate this, but we are talking about something that gets out of our committee, into Post Office and Civil Service jurisdiction. But, nevertheless, we need to carry that word back to them because there are certain areas we don't have the jurisdiction over. But we really appreciate getting your views.

Mr. **Freer**. Thank you, sir. We are making this known, not only through the local facility, but through the regional office of the Office of Personnel Management.

Mr. **Edgar**. One of the problems that John Paul is referring to is we have as many as 185 cubbyholes we all work in called committees and subcommittees, and jurisdiction is a tough problem. We serve on the Surface Transportation Committee. We have jurisdiction over all forms of surface transportation, except railroads. We can talk about railroad crossings occasionally, but the actual administration of the railroads is over in Energy and Commerce.

It is difficult sometimes to cut across those lines, but we will not only take that message back, but perhaps pursue it in a little more detail.

STATEMENT OF JONATHAN FITTS

Mr. **Edgar**. Mr. Fitts, please identify yourself for the record and give a brief description of your operation.

Mr. **Fitts**. I am Johnathan Fitts, the Director of the Veterans' Administration Medical Center at Fort Lyon, Colo. Fort Lyon is the primary provider of long-term psychiatric care for this area. We have 225 psychiatric beds in addition to 112 medical beds, primarily long term also. We have a 37-bed nursing home unit and a 24-bed alcohol rehabilitation unit. Fort Lyon is unique primarily for its remoteness. We are located 90 miles due east of Pueblo in the lower Arkansas Valley, about 80 miles from the Kansas and New Mexico borders.

We are in an area with a population of less than 6,000. We are the largest employer, not only in our county, but in any contiguous county.

Mr. **Edgar**. How do people get there?

Mr. **Fitts**. There is no local public transportation, by the way, so that everyone does have to commute. The nearest town is 6 miles, and the nearest town of any size is 25 miles.

Mr. **Edgar**. Let me ask another question: With 6,000 people in the county, how many employees do you have on your staff?

Mr. **Fitts**. 650 full time.

Mr. **Edgar**. You are the largest employer. Proceed.

Mr. **Fitts**. To address a couple of the concerns that I have heard today, first from the ex-POW representative. We have a provision for POW's who come to Fort Lyon for an examination where we admit them and keep them overnight if they desire. In the course of this 2-day examination, they will be seen by a social worker, a psychologist, and a psychiatrist, in addition to a full medical workup, which a nurse practitioner does begin, but is then finished by a medical doctor.

Any of them who have felt that they have not received enough attention from us in the course of this examination, we would of course welcome back for all or any part of it.

Also, some of the service officers mentioned concerns over geriatric care. We do have a new nursing home at Fort Lyon and have plans for 1986 to complete an additional 37 beds with a second floor, and we have hired a full-time geriatric physician and a psychogerontologist, a new field in psychology.

So we are trying to prepare for the onset of that medicine at our location. One-third of our patients, as of Friday, were 65 and over. On the issue of remote care, we are one of the hospitals that, as Mr. Mullon has mentioned, that uses a medi-van, a vehicle that goes to Pueblo, which is the largest population area to provide services every other week, and we also have several foster homes and four halfway houses for patients in our alcohol rehab program to bridge the gap of the distance between us and the population centers.

Mr. **Edgar**. I want to ask you the same question I asked Mr. Freer.

What are the two or three things that you can think of that you need besides more population? What is it that the VA could do to assist the kind of work you are doing in that remote area?

Mr. **Fitts**. I would have to echo Mr. Freer's need in that we have difficulty recruiting particularly allied health personnel. We were very fortunate recently in the recruiting of physicians and nurses because we do have difficulties because of the inadequate grade structure for the lower grade allied health technicians. We have a great deal of difficulty in procuring any specialists, although the VAMC here in Denver helps us with a weekly flight that brings specialists to us. We do not even have the opportunity to contract, because they are also not available in the community in the valley itself. We are by far the largest health care provider in the area as well.

The other thing is funds for either more outreach efforts or more travel funds, beneficiary travel funds, so we can either bring care to the veteran or the veteran can be brought to us. And the last thing would be one concern I have over the physical plant which has been greatly renovated at Fort Lyon, that is now very attractive, with one exception. We had last year 27 days of temperature exceeding 100 ° Fahrenheit, and we are not now a fully air-conditioned hospital, and we have had a great deal of difficulty in securing the funds to become so obviously because of the great expense involved. If there was——

Mr. EDGAR. Let me stop you there. Mr. Regional Director, are there plans to fully air-condition a facility in an area that has that kind of heat?

Mr. MULLON. I don't know of any plans at this point to air-condition Fort Lyon, Colo. If it meets certain criteria for construction, I don't really know offhand, but I can provide that to the committee.

Mr. EDGAR. It would be helpful to know. I know that originally there were some decisions made in terms of psychiatric care, not to provide air-conditioning at some point where there was a financial crunch. But I think that was a long time ago. We have been visiting hospitals, particularly the psychiatric units, that are not air-conditioned. So obviously somebody made a budget decision that air-conditioning was not necessary. It is a different thing when you don't air-condition something in Philadelphia or Chicago, than not air-conditioning something in the area you are describing.

Mr. MULLON. There have been many psychiatric facilities air-conditioned recently. There is no rule against that. However, it must meet certain temperature requirements in the area. I am not that familiar with them, but we can provide it to the committee. It has to reach a certain temperature over quite a period of time.

Mr. FITTS. I would like to say for the medical district and for Mr. Mullon, we have been moved up to the No. 1 priority for air-conditioning. We have put the air-conditioning into our 5-year plan and we would hope something would come of that.

Mr. EDGAR. Do you have fans in the meantime?

Mr. FITTS. Yes, and we do meet the criteria for temperature.

Mr. EDGAR. I would just underscore in terms of our hearing record, it would just seem to be commonsense the description of the facilities which you describe, having been upgraded, and some of the areas not being fully air-conditioned is a real problem. We will pursue it from our end. And I would hope that the region would also pursue it to make sure that it does have the high priority you mentioned. It is just unconscionable that mental patients, particularly, would suffer a different kind of climatic condition.

We still have hospitals that are not fully air-conditioned as well. But I would think it is important to put a priority list together in a 5- or 10-year plan to make sure at the end of the 10-year plan, we don't have the anomalies that exist.

Mr. FITTS. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

UPDATE ON CENTRALIZED AIR-CONDITIONING PROPOSAL FOR VAMC FORT LYON, COLO.

Attached are copies of correspondence of 9-17-82 and 1-28-83 detailing Fort Lyon's request and justification for centralized air-conditioning. Our project #567-066 is in the APF for FY84.

In addition, note VACO Facility response of 1-5-83 attached to suggest interim measures be developed pending design/approval process for central HVAC.

In light of the above suggestion, we have included in our Five Year Plan (1985 to 1989) a request for $142,000 for Building #3 (Auditorium) and Building #4 (long term psychiatric patient units) for $158,000. Both requests have previously been disapproved in VACO. Our Five Year Plan has not yet been returned from VACO.

We also have a project to air-condition a portion of Building #6 (Alcohol Treatment Unit) for $30,000. These patients are especially vocal in their complaints about the temperatures on that unit. The Engineering Officer Task Force put this on their priority list for FY85.

Two pending ward renovations will require A/C, if the centralized project does not go through. Air-conditioning will be included in the design of 4F (Psych) and 5B North and South (Medical/Psych). Ward 5B South is approved and funded for 1984 without air-conditioning.

JAN 28 1983

567/138

Midwestern Regional Director (10BA5/10A4B7)
Department of Medicine and Surgery
Veterans Administration Central Office
Washington, D.C. 20420

THRU: Medical District Director (MDD24)

SUBJ: FY 84 Project Activation Listing, RCS 10-304

In accordance with DM&S Circular 10-81-280, the following information is submitted:

a. VAMC, Fort Lyon, Colorado, HVAC Central System: This facility is not now adequately cooled or ventilated. Cooling is by evaporative coolers and window air conditioning units and several small DX package units. The 30 year average heating Degree Days is in excess of 1450. It is proposed to remove existing systems and install a centralized chilled water system for Buildings #3, 4, 5, 6, 7, 8, 19, 24, 152 and 508. Buildings will require from 1 to 3 air conditioning air handling units with subsequent VAV systems and/or fan coil units, ventilation system, heat wheels, attic insulation, chilled water piping, secondary heating and necessary controls. An approximate 3500 to 4000 SF addition to existing Boiler Plant building will be required to house the chillers, pumps, control system, switch gear and subsequent piping. Space is available for an addition to existing building or for construction of a new building and cooling towers. It is suggested that a centralized computer system be installed for the new system (i.e., Delta 2000 and Q-80/Powers 1500). Emergency power generation for Boiler/chiller plant is recommended.

b. Project #567-066

FY 84 A/E

FY 87 Construction

FY 88 Completion

estimated cost $8.5 million

c. Requirements for Maintenance of Additional Space

FTEE:	FY84	FY85	FY87
1 Operations Foreman	None	None	12
5 Utility Systems Operators, WG			
2 Air Conditioning Refrig. Mech., WG			
1 PM Inspector/Maint. Mech.			
1 Electrician			
1 Pipefitter			
1 Graphic Control Operator			

ALL OTHER: None

PERSONAL SERVICE DOLLARS: $250,000 approximately

ALL OTHER DOLLARS:

Utilities	$300,000 annual
Tools/Equipment	100,000 initial additional
Supplies - initial	
Filter Frames, filters, etc.	100,000
Supplies - recurring	10,000/quarter
NRM&R	20,000/year
Contract Services	
Equipment	18,000/year
Controls	10,000/year

TOTAL REQUIRED DOLLARS: $838,000

d. Requirements for additional resources other than for maintenance of space: No new or additional resources have been identified at this time. There are no anticipated changes in bed allocations.

JONATHAN F. FITTS
Director

cc:
001
04
+ 2

DZAKEN/syr/138/1/27/83

567-066

116B

Mid-Western [illegible]

The [illegible]
[illegible]
SEP 17 1982

567/00

'82 SEP 20 AM 10:48

RECEIVED

Mid-Western Regional Director (10NA5)
Department of Medicine and Surgery
Veterans Administration Central Office
Washington, DC 20420

SUBJECT: Request for Air Conditioning

1. In keeping with our mission of rendering optimal quality of life for the long-term veteran patient, Fort Lyon's continuing and urgent concern is that an optimally healthy environment cannot be provided for our veterans under the present adverse conditions of lack of air conditioning at this Medical Center. Construction of an HVAC central air conditioning system, previously scheduled to begin in 1984, has been rescheduled to begin in 1987, five years hence (see Attachment A). To continue to treat the aging veteran under the present conditions means: (a) exposing veterans to greater than necessary health care risks, and (b) excessive health care costs not only for this facility but also for the entire VA system. These two factors are addressed as follows:

a. PATIENT CARE FACTORS

(1) Climate: Fort Lyon VA Medical Center is located in Southeastern Colorado in what is known as the "Great American Desert", where summer temperatures range as high as 112°F and have averaged 90.3°F for the months of June, July and August the last two years. Most significantly, 54 of the 92 days in the period June through August of 1981 had temperatures in excess of 90°F; 25 days were 100°F or above. ~~This past~~ In that summer 1982 the area experienced 48 days over 90°F, 14 of which were 100°F or above. Additionally, the relatively milder months of May and September in this area occasionally have temperature extremes in the 90's and 100's.

(2) Therapeutic Environment: All 14 of our patient care units housing an authorized 342 beds are without air conditioning and are ventilated only by fans or swamp coolers, neither of which give relief from the heat spells common to this area. Temperatures on units in the dayrooms and bedroom areas have been measured as high as 94°F during these hot spells. The implications of these hot climatic conditions and uneven environmental control are grave considering our chronic aging population.

(3) Patient Demography: Based on a sociometric study done on 356 inpatients at Fort Lyon VA Medical Center in 1981 (see Attachment B), our typical veteran, excluding the patients admitted for the 63-day alcoholism treatment program, is a middle aged, chronic, psychiatric/medical patient with three to four prior hospitalizations and averaging a three year stay for treatment of a service connected or non-service connected condition.

The mean age for the 125 organic brain syndrome and medical patients in this study was 64.52 and 64.27 years, respectively, indicating that fully one-third of our population is geriatric. With all present population projections predicting dramatic increases in the aging veteran population who will seek services within the VA, we may expect that not only will there be a greater number of aging veterans in the VA system, but also than an even greater percent of our veteran population will be geriatric patients. As the VA is actively seeking to improve geriatric care throughout the system, it is quite incongruous for Fort Lyon VAMC not to be able to provide protection for our aging veterans from heat extremes.

(4) Medical Risk: The majority of our veterans have not only psychiatric but also multiple medical problems such as COPD, high blood pressure, etc. It goes without saying that heat extremes are medically contraindicated. (see Attachment C).

(5) Violence Risk: Data analyzed by the Committee for the Prevention and Management of Disturbed Behavior (Violence and Suicide) suggests that excessive heat is one factor contributing to periodic increases in violent incidents during the summer months (see Attachment D). Experienced clinical staff are well acquainted with this phenomenon, and need every possible consideration to aid in their management of violent patients referred to Fort Lyon from other Medical Centers who are not equipped to deal with this type of patient on a long-term basis.

b. COST EFFECTIVENESS FACTORS

(1) Manpower and Maintenance/Maintenance Costs: Installation and quality maintenance of the 109 swamp coolers in patient care areas cost $31,409 this last year. The present ventilation and cooling system has been inadequate to alleviate our summer heat problem on the units, with much downtime and maintenance required. Fort Lyon's present electrical system is outdated and does not contain the voltage capacity necessary to handle even window air conditioning units.

(2) Work Environment: It is quite clear that hot environmental conditions not only adversely affect patients but also adversely affect staff productivity and efficiency. Improved staff morale and energy levels would in and of itself be cost effective and assure better patient care.

(3) Projected Cost Savings: Costs of major construction of central air conditioning at Fort Lyon projected at $8,500,000, will by any estimate rise within the next five years. If, in five years, costs rise only 10 to 15 percent this will mean an increase in the total project cost to the VA of $850,000 to $1,275,000. A conservative estimate of cost increases would predict a 10 to 15 percent rise in costs of construction per year. Going forth with the major air conditioning project as originally proposed for 1984 could conceivably save the VA $1 million to $2 million.

2. In summary, the present situation is that our older psychiatrically and medically impaired veterans in long-term residential care are periodically

exposed to unnecessary heat extremes with consequent increased risk to their health. Immediate attention to environmental deficiencies at this Medical Center would mean: (a) reduction of health care risks and risk of injury; (b) savings in labor, equipment and maintenance costs, for this facility as well as long-run savings in major construction costs; and (c) increased employee efficiency and morale.

Pending electrical rewiring projected for accomplishment in 1983, a "stop gap" alternative solution to our air conditioning problem would be the purchase and installation of window air conditioner units at an estimated cost of $350,000 to $400,000.

3. A high percentage of our patients are "permanent residents" and may spend the remainder of their lives at this Medical Center. In view of this fact, your consideration is requested that the initiation date for HVAC central air conditioning construction at Fort Lyon VA Medical Center be reinstated to 1984.

JONATHAN F. FITTS
Director

Attachments

CC: 11/00

138

R. STEVEN GARRETT, Ph.D./D. K. GREENLEAF, D.O./aq/09-16-82 411 001 00 002

Department of Medicine
and Surgery

Washington D.C. 20420

Veterans
Administration

1238

January 5, 1983

In Reply Refer To: 10A4A3

Director (00/138)
VA Medical Center
Ft. Lyon, CO 81038

SUBJ: HVAC Central System

1. Installation of a centralized HVAC system usually takes at least 5 years to schedule, design and construct. Your facility's Five Year Plan calls for design of a central HVAC system to start in 1987. Therefore a nine to ten year wait for central air conditioning would probably indicate a need for your medical center to take some interim measures to provide some additional cooling. You may wish to submit a project to install some packaged A/C units in critical areas.

2. An interim A/C project submission should include a set of preliminary plans, including necessary electrical distribution, and a cost estimate.

By Direction of the Chief Medical Center:

Roy C. McCracken
ROY C. McCRACKEN
Director, Facility Engineering, Planning
and Construction Office

Mr. **Edgar**. Mr. Lindsey, would you identify yourself for the record.

STATEMENT OF ROBERT LINDSEY

Mr. **Lindsey**. Thank you, Mr. Chairman. I am Robert Lindsey, Jr. I am the medical center director of the medical center at Salt Lake Center, Utah, and the medical district director for medical district 24.

You have alluded to the geographical size of our district. It is really a large district. It extends some 1,100 miles north to south, and 1,100 miles east to west. It includes the States of Utah, Colorado, Wyoming, and Montana, and parts of the States of North Dakota, Nebraska, Kansas, Idaho, and Nevada.

There are eight VA medical centers in this medical district. Some of the obstacles to providing care in this medical district are ones which have been mentioned, the sheer geographic size of the medical district, some 490,000 square miles; the topography of our primary service areas, the dispersion of population, and the harsh climatic conditions.

One of the primary thrusts of the medical district is to provide outreach into rural areas to meet some of the needs of those veterans who by their own choice choose to live in rural America and choose not to live adjacent to a VA medical center. And in doing that, I think we have some innovative approaches. You have heard about some of them this morning. We do have papers developed which explain those approaches in some detail. We could provide that for the record.

Mr. **Edgar**. We will accept those for the record.[1]

Can you repeat again just for the record your connection with the hospital that Mr. Freer was talking about. You send teams up there. Is that once a week?

Mr. **Lindsey**. What we do is essentially we send traveling teams in the areas of surgical subspecialties, optometry, podiatry, and the like, and we send——

Mr. **Edgar**. Is that by area?

Mr. **Lindsey**. We send an aircraft from Salt Lake City to Fort Harrison, Mont., on a weekly basis.

Mr. **Edgar**. What is the cost of that aircraft?

Mr. **Lindsey**. The cost to you, after you offset what it was costing us previously in terms of the huge beneficiary travel cost associated with traveling individual patients by air to Salt Lake City when they needed care is a savings to us of approximately $20,000 a year.

Mr. **Edgar**. What does it cost you to provide that?

Mr. **Lindsey**. I would say approximately $100,000 a year.

Mr. **Edgar**. Is it your own airplane?

Mr. **Lindsey**. It is an airplane that we charter. We have an aircraft which is pure jet, two engines, two pilots. We send up teams of specialists. And any patient ready for discharge on that day we send back to Fort Harrison. And we land early in the day and then we hold the clinics that day for as long as it takes for the clinics to be held. The plane waits for us at Fort Harrison and then when the clinic is over, whether it is 3 o'clock in the afternoon or 8 o'clock at night, then that staffer and any patients which have to be transferred back to Salt Lake City for a higher level of care come back there. We do the same thing with Grand Junction, Colo., but approximately twice a month.

---

[1] See pp. 104, 118.

Mr. **Edgar**. John Paul.

Mr. **Hammerschmidt**. What type aircraft is it?

Mr. **Lindsey**. It is a Lear jet, Citation.

Mr. **Hammerschmidt**. It has a rather small capacity.

Mr. **Lindsey**. In one plane, we can accommodate nine passengers.

Mr. **Edgar**. One other question. If we were looking at the future of veterans health care in this region, is it too fanciful to think that a plane or two in the medical district, sort of like a medical evacuation helicopter program that you might have around an urban center, or even down in Honduras, they have a team of medical helicopters that provide service to both people fighting in wars and the refugees that are involved—there are different types of those services. It seems to me with the distances you are traveling and the contractual relations you are making that it would not be—it might be hard to sell in Congress, but it might not be a bad idea to have some strategic thinking as to aircraft need in the area, and whether or not we could save some funds in the long term by investing that $100,000 you are spending and the $100,000 somebody else is spending to get a slightly larger plane with a couple of pilots who would keep it well serviced and use it for a variety of strictly medical transportation needs as part of an upgrading of that quality of care.

One of the things you are doing is what we are trying to say with our hearings—how do you get the opportunity to prevent more expensive inservice patient care—if we can take some of the skilled professionals out in the field occasionally, with quick turnaround and convenience, it seems to me we are doing what you are suggesting and saving some money.

Mr. **Lindsey**. That is an excellent point. Whether it is more economical to charter, go the way we are going, or to have our own air force——

Mr. **Edgar**. The VA Air Force—I can just hear it now.

Mr. **Lindsey**. I would suspect based on some studies we have done we are now doing the more economical thing. But I might add what we are talking about is already established in Salt Lake City, where there is housed at both the LDS Hospital and the University of Utah the capability for both fixed-wing aircraft and for helicopter aircraft who travel out into the rural areas and do pick up patients, newborns, for example, and bring them back to the centers where care is required. So there is a mechanism for doing that. And we tie into that by contract.

Now, that is centered in Salt Lake City. And, of course, it takes time and the great distances to be traveled. But the helicopter aircraft which are available are those which can accommodate mountain accidents as well as those which can accommodate problems in more level areas.

Mr. **Edgar**. We have a sharing agreement with the military in terms of sharing medical facilities. In this respect, have there been discussions with the military in the area in terms of sharing resources of the airplanes and helicopters that they have?

Mr. LINDSEY. Not to my knowledge. But this is also, I would add, a specialized approach, because you not only need the aircraft—you need the aircraft equipped to handle medical emergencies. And, of course, you would need the medical staff to be on that plane, the specialties that you would need for the particular case at hand.

Mr. EDGAR. Could you use the service more than 1 day or up to the capacity of that?

Mr. LINDSEY. We could expand the program. What limits us, of course, are the dollars obviously. We always have to live under a budget limitation, no matter what the budget is. We feel that at the current time we are meeting the main need. But that could be expanded as demand upon our system grows.

Might I add one thing concerning an issue raised earlier in the area of psychiatry. The medical district has been wrestling with the problem of psychiatric care for eligible veterans now for well over a year. In looking at our 1990 veteran projections, we have, through a series of meetings with the chiefs of psychiatry around the medical district and with review by our district planning board and medical district directors, we are planning to increase the number of psychiatric beds in the medical district to meet a growing demand for psychiatric care, and to place some beds in some of our VA medical centers which do not have them now, and to increase beds in centers where demand is overwhelming, such as Denver.

[The statement of Mr. Lindsey appears on p. 92.]

Mr. EDGAR. Thank you.

Mr. Smith.

STATEMENT OF CARLTON SMITH

Mr. SMITH. Mr. Chairman, if it would be acceptable to you, sir, I would like my prepared statement to serve, and rather respond to questions that you would like to have.

Mr. EDGAR. Without objection, your full statement will be made a part of the record.

[The statement of Mr. Smith appears on p. 170.]

Mr. EDGAR. Thank you. You can either, if you wish, respond to some of the issues raised earlier or let us begin and then sum up at the end.

Mr. SMITH. I think perhaps in one area I would like to make a statement, and that is in the area about the issues of psychiatric care at Denver.

I would like to start by saying that the Denver psychiatric program is fully accredited by the Joint Committee on Accreditation of Hospitals. It is administered, managed, and supervised by Dr. David Starret, a nationally known psychiatrist, and a tremendously prominent Coloradan in this particular area.

Dr. Custis has responded to the national office of the American Legion with the results of the Medical Inspector's review of the issue of the suicides in two cases at Denver, and that just may not have trickled down to the service officer in Colorado but the Medical Inspector found in essence that the very thorough investigations that were accomplished and everything found that there was no negligence.

Mr. EDGAR. Mr. Smith, in that area, would you make available to the committee that report when it is available?

Mr. SMITH. Yes, sir.

Mr. EDGAR. And also would you make available to us the incidents reports on the two suicides and any other related issues such as the ones that were alleged in terms of the murders that occurred in 1983.

Mr. SMITH. Yes, sir, I will be glad to do that.

Mr. EDGAR. Thank you very much.[1]

Mr. SMITH. I would like to say that the chairman asked a very astute question I think during the course of the discussion on this subject when he asked about the issue of construction, because one of the reasons for the patient's unfortunately successful suicide, the patient hammering out the screen, while we cannot tell how long he had been at it, and I cannot talk to the point of the time—it was over a day when there was construction noise directly above the room in which he was located on the eighth floor. We saw the psychiatry area today, and you saw our double-bunkbed structure and things of that sort. We have had considerable discussion about the impact of construction on psychiatry with our total clinical and management staff. There would be the problem, however, if we felt that it reached a point where it really was hampering care, we would be in a position of giving no care, because we would have to close the psychiatric wards that are immediately adjacent to the construction areas. And then we would have no treatment available, and we have a tremendous demand factor.

I want to make just one comment about the patient who was involved in the shooting. That patient was cared for after his VA hospitalization at several other medical institutions, including the State hospital in Colorado, neighborhood medical centers, and there was a significant problem in that particular case, in that a Colorado judge ordered the Veterans' Administration not to administer any medication to that patient while keeping him on a hold. And in the opinion of the treatment team, there was no way that they could successfully treat the veteran without his medication. It was a very unusual event. The treatment team feels the judge's decision interfered very significantly in their ability to treat the veteran.

Then I would respond to any questions.

Mr. EDGAR. Mr. Smith, could you just indicate for us what the turnover rate is in the psychiatry area in terms of staff and personnel?

Mr. SMITH. The turnover rate in psychiatry is very low. We have, compared to the rest of the country, a very heavily staffed psychiatry service, both inpatient and outpatient. One of Dr. Starret's attributes as a manager has been his ability to convince top management of the need for manpower. I cannot tell you the exact turnover rate of the employees within the psychiatry service. I do know that generally it is very low.

---

[1] In order to conform to the provisions of section 3305, title 38, United States Code, mandating the confidentiality of medical quality-assurance records, the requested material is retained in committee files.

Mr. **Edgar**. We would appreciate it if you could provide that for the record.

Mr. **Smith**. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

The turnover rate of Psychiatric Service employees at Denver VA Medical Center for FY 83 was 25 percent; professional employees had no turnover; rehabilitation technicians accounted for 10 percent and clerical personnel 90 percent of the turnover. Nursing Service turnover for the entire medical center stabilized at 30 percent in FY 83; Nursing Service statistics are not part of the 25 percent turnover rate mentioned above.

Mr. **Edgar**. Throughout our visits to different VA facilities we have noted that in recent months and years, particularly with the readjustment counseling centers and contract services that we have had, that the relationship of the VA to Vietnam veterans has improved considerably. But there are still many allegations and reports of insensitivity by doctors reviewing VA cases that are Vietnam-era oriented, problems with agent orange examinations and testing, problems with understanding the full impact of delayed stress syndrome, psychiatric problems of putting Vietnam veterans within the mainstream of the psychiatric service rather than separating out such as the combat units that we have had an opportunity to visit. But the whole question relates to the sensitivity of the staff and personnel to Vietnam-era veterans. Have you been able to assess that issue, whether it is improving or whether or not there is a problem in any of your health care areas as it relates to Vietnam veterans, in terms of attitude?

Mr. **Smith**. Within the Denver VA Medical Center and in its relationship with the outreach center I must say it is one of the most superb relationships I have seen. And I think that is a factor that can be attributed to both staffs. They hold joint clinical rounds. Dr. Seidel mentioned to Mr. Hammerschmidt this morning one of the first rounds he attended when he came to Denver was the clinical psychologist from the outreach center presenting a patient on the in-service, and the cooperation was excellent. Victor Raymond mentioned that same thing to me on Friday. Our medical staff does include several Vietnam veterans. There are many Vietnam veteran physicians as a matter of fact on our medical staff including several people from within the psychiatry service.

There is just a good, cooperative effort. I think one other thing, and I discussed this with Mr. Galloway and the prisoner-of-war group yesterday, we had about a 2-hour meeting—that if a VA medical center designates a concerned, caring, knowledgeable physician to manage the special attention programs, agent orange, POW, and all of the rest of them, then you can build a continuing relationship with an individual who is going to be there, who is going to know the patients, and who is going to know his or her business, and I say that because in our case Dr. Sylvia Ogler is our assistant chief of ambulatory care and the individual who handles all of these special programs, and therefore influences all of the staff to be as considerate and caring and thorough and everything else as they can be. But I think the relationship between the Denver Outreach Center and the Denver Medical Center is superb.

Mr. **Edgar**. I have just two additional questions.

Mr. Freer, Mr. Fitts, if you would like to respond—are you experiencing recruiting and retention problems with your security force or police force?

Mr. **Smith**. The answer to that question is yes. And it is because of the Denver pay scales within its police department. It is preventing us as well from attempting to provide upward mobility for minorities. We cannot hire a female policewoman on our security force and we would like very much to have a certain number of the officers, females, to deal with some of the issues and problems that we have. But the Denver Police Department hires them at about $5,000 more than we can pay for them.

Mr. **Edgar**. Mr. Fitts.

Mr. **Fitts**. Not a problem in the remote areas.

Mr. **Edgar**. Do you have sheriffs?

Mr. **Fitts**. Like everything else, we have the best police force in the area, too.

Mr. **Edgar**. Mr. Freer.

Mr. **Freer**. Let me give a twofold answer to that. I served in downtown New York, Manhattan. We had extreme difficulty getting qualified people for our police force, with the grade level there in a large city. At Grand Junction, a predominantly more rural area, we do not find this to be a problem. We are able to recruit and retain qualified people.

Mr. **Edgar**. Let me just ask you one final question. We are interested in the area of community or private health facilities, and what they provide to citizens, some of whom are veterans in some communities. Have any of you as hospital directors been in contact with any of your community or private adult day care health care facilities? I would doubt in the rural areas there are significant numbers of them, just simply because of the size, but you may have something like community nursing services or home health centers or adult day care centers.

Mr. **Fitts**. We have a geriatric counselor in lower Arkansas Valley. We do operate the only day treatment center in the area. With our transportation run, we have been assisting some of the other geriatric institutions.

Mr. **Freer**. I serve on the board of directors of our county mental health association. Our facilities for veterans in our community are very limited in Grand Junction.

Mr. **Smith**. I am sorry I could not specifically respond to the question. With our newly starting hospital-based home care program, the staff of that program are seeking those resources.

Mr. **Edgar**. One of the things I would just leave you with, it is really a challenge. We have really struggled with how do you provide better health care and long-term health care to veterans that may not need institutionalization, or who can be provided alternative care, without necessarily mainstreaming them, but providing it in their home, their home area. Particularly around some of our urban centers we find there are services that are out there. I would like to see some experimentation, ways in which we can save some money by having people who do not need the urgency of acute care, or do not have the resources to have nursing home facilities provided for be cared for in their home or have adult day care centers provided where people could go and perhaps on a contract fee basis be provided some service. If you have any thoughts in that area for the record it would be helpful.

The challenge is that by January 1 or so, when we sit down in Washington after our full set of hearings, and begin to think of legislative agendas, we are going to be thinking about the whole future of the veterans' health care system. The Grace Commission came out with a report which they later said was not accurate, and I believe it is not accurate. But in the 9 years I have been in Washington, throughout the fringes of the medical community there have been people looking at ways for dismantling pieces of the veterans' health care system. There is bipartisan, strong support for keeping that system in place. I am not sure we can defend the system adequately unless it is at the cutting edge of health technology. So I am asking those of you in the region and in the hospitals who are professionals to go back and talk to your staffs, nursing staffs, medical staffs, affiliated staffs, with creative hospitals, to do some dreaming as to what you would like to see the veterans' health care system look like in the year 2000—how many hospitals do we have to build where there is population growth, how many hospitals do we not have to build because we have been innovative in a particular way, what creative things can we do out of our experience with the kind of thing you are doing, the aviation exchanges, the mobile exchanges, the miniclinics, can we have shared resources with community facilities, still keeping the integrity of the veterans' health care system but providing more veterans—perhaps less veterans—but more veterans needing health care services because of age that care in some new ways. I would hope for the record you might send us a letter, write us a report, talk to your staffs, and get back to us.[1]

Mr. MULLON. We appreciate that challenge, sir. We have a task force in the VA which is looking into just that area. We will be glad to provide your committee with our results to this point.

Mr. EDGAR. Thank you. I yield to my colleague.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I have about 15 questions prepared here, but you know sometimes we drag out these hearings until 6, 7, 8 o'clock at night. We are not going to do that today. So I would like to submit those questions. I believe I will submit them to you, Mr. Mullon, for a response, at the regional level. You might want to get some directors to respond as well. I do want to ask two or three questions that I think should be responded to here for the benefit of the very patient veterans' organizations that have been here all afternoon, and we appreciate their patience. We appreciate your patience.

Mr. Smith, there is one comment by the American Legion department service officer that was made that is somewhat disturbing. I want to give you an opportunity to respond to it.

I will quote in part from her statement:

> Because of the large number of service-connected veterans seeking treatment at this hospital, it is very difficult for a veteran with a non-service-connected disability,

---

[1] Not received at time of publication.

everyone who meets the eligibility requirements set by Congress, to obtain outpatient treatment from our VAMC's.

Could you respond to that?

Mr. SMITH. Yes, sir. In part of our briefing to the committee this noon, in response to your question about our restrictions on ambulatory care, I think I pointed out to you that we do not have any restrictions on ambulatory care, and we do everything we can to take care of as many non-service-connected veterans as we can. Last year we had 145,000 outpatient visits at Denver. The ratio is a 60-percent service-connected, 40 percent non-service-connected level, and that relates to our being the clinic of jurisdiction for the State of Colorado. But we have no turnaway policy or procedure except where it is physically impossible because of staff or space to enter people into the care program. Now, with 157 beds closed, we are not doing a lot of elective surgeries and things of that sort. There are only four medical specialties where we occasionally cannot take more non-service-connecteds because of the amount of staffing, and that is neurosurgery, opthalmology, orthopedics, and another. But we have no prohibitive policy and increased our level of visits from 125,000 to 143,000 over the last year.

Mr. HAMMERSCHMIDT. Thank you.

Mr. Mullon, I think I need to ask this question, and then also I would ask each hospital director to respond for the record—maybe not today, but because it is of great concern to these people who have been sitting here.

Mr. Mullon, what has been your experience with the new law, Public Law 97-37, giving priority medical care to ex-prisoners of war and providing special medical examinations for them, and I also ask each hospital director to respond.

Mr. MULLON. We have developed new forms now which help us and which were mentioned earlier today. We started within the region 2 new training programs for staffs of each medical center in how to relate to the problems of the ex-POW's. Those programs have been put on in districts 18 and 20, and we are moving them now on to the other districts.

In each institution, each medical center, we have designated one individual, a physician, to be the key person or coordinator of all ex-POW examinations. We have in each district an overseer of that POW examination process. That person is also a physician, and hopefully that person in most of our districts is a former POW or has worked extensively with former POW's.

We have a little way to go, or a long ways to go, depending on how you perceive it. But we realize the importance of this program, we realize the significance of these individuals, we realize the importance of doing the examinations correctly, and spending the time to do them. We are working hard on it, and we intend to improve.

[Subsequently, the Veterans' Administration furnished the following information:]

Responses from the Directors at Grand Junction, Colo.; Denver, Colo.; and Fort Lyon, Colo. VA Medical Centers regarding treatment of former POW's follow:

TREATMENT OF FORMER PRISONERS OF WAR, VETERANS' ADMINISTRATION MEDICAL CENTER, GRAND JUNCTION, COLO.

This facility has formulated a policy to ensure that Former Prisoners of War are afforded special treatment and medical care in a timely, courteous and emphatic manner. Every employee shares and cooperates in the sensitive effort we extend to the former POW.

We fully support priority treatment of former POW. Every available treatment and service to which these veterans are entitled are administered in a "red carpet" manner. Each former POW who applies for medical benefits is assigned a physician who becomes his/her primary treating physician.

The Chief, Medical Service, and Chief, Psychiatry Service are responsible for the overall coordination of the comprehensive program for POW's, including the assignment of the primary-care physician.

The Chief, Medical Administration Service serves as administrative liaison coordinating all administrative processing, including eligibility verification and medical records labeling.

The medical and administrative files of these veterans have affixed a green POW label in a prominent position on the front of the patient's records. This is done after verification of this status. The nationwide master list of the former POW is used for eligibility purposes.

Every assistance possible is given by the Chief, Medical Administration Service to resolve ex-prisoner of war status for those veterans not included on the master list. Medical Administration Service assists the former POW to ensure continuity of administrative services with other VA facilities and other government and non-government agencies.

Our commitment to these veterans and their families is unequivocal and we respond to their needs at every opportunity.

WHITE PAPER "EX-POW EXAMINATIONS," DR. STEVEN OBOLER, VAMC DENVER, COLO.

As of January 1, 1983, there were approximately 90,000 living former POWs, of which 454 reside in Colorado, most from the European theater in World War II. Overall, approximately 50% of former POWs are service connected (approximately 60% of POWs from the European theater in World War II are service connected).

The two main concerns of the new POW examination program are compensation and medical care. Most POW examinations performed will be on former POWs who have not previously had any contact with the Veterans Administration, either through application for compensation and pension or application for medical care, or POWs who have completed C&P examinations but have been turned down by Rating Boards.

The issue of ex-POW examinations and follow-up has been handled well at the Denver VA Medical Center through attention to the following areas: (1) quality control of the ex-POW examinations, (2) appropriate follow-up of veterans receiving POW examinations, (3) review of the ex-POW questionnaire, and (4) education of VA staff, patients and the public about current knowledge of disorders they may suffer from.

POW EXAMINATIONS

Through an arrangement between the POW Coordinator and the Administrative Medicine Section, POW examinations are accomplished through the Compensation and Pension Section. 90% of POW examinations are initiated by the VA Regional Office for compensation purposes. The other 10% are self-referred (through other ex-POWs, bulletins or by their primary care physician). All examining physicians are specifically educated on how to perform examinations, are giving background information regarding ex-POWs and a list of disorders they may continue to suffer from. Because of the sensitivity issue, it is preferable to have as few physicians as possible performing these examinations. Nurse Practioners, Physician's Assistants or residents in training do not perform these examinations.

An ex-POW examination consists of a comprehensive physical examination including a review of the ex-POW questionnaire, VA Form 10-0048, which is mailed two weeks prior to the veteran's scheduled appointment. This examination takes approximately two (2) hours. The veteran then undergoes a 60 minute psychiatric evaluation. The Senior Staff Psychiatrist reviews all psychiatric examinations for adequacy. The veteran is then referred for all necessary laboratory, x-ray and other special examinations including sigmoidoscopy, if clinically indicated. The entire examination usually takes the better part of a working day to complete.

FOLLOW-UP OF EX-POW PATIENTS

The veteran is then scheduled to return for a follow-up review of all their test results approximately two weeks following their initial examination. During this two week period, the POW Coordinator reviews all available medical records including the veterans CHR and service medical records in the claims folder. At the time of the exit interview, the POW Coordinator arranges for any follow-up medical or psychiatric care.

Completed examinations are returned to the Regional Office and copies are placed in the veteran's medical record. In addition, copies are also maintained by the POW Coordinator for further Central Office review.

The most common medical finding as a residual of POW confinement is mild peripheral neuropathy. The most common psychiatric findings are post traumatic stress syndrome and/or anxiety related disorders.

EDUCATION

Ongoing education regarding POWs is provided to all VA staff working with these veterans.

Veterans are being educated by the POW Coordinator at the time of the exit interview regarding the results of their examinations and any necessary medical or psychiatric follow-up. Veteran concerns and questions are also discussed at this time, particularly in reference to future availability of dental, audiology, ophthalmology and psychiatric care.

In addition to a POW Coordinator, Dr. Sylvia Oboler is designated the Senior Medical Clinical Coordinator for Medical District 24 and as such, initiates and coordinates comprehensive conference calls with all other POW Coordinators within our Medical District. Some topics discussed during these conference calls include background for initiation of POW examinations, concerns of POWs, requirements of the POW exam, implementation of the POW exam project, relation of C&P process to POW exams, POW outreach efforts and discussion of available resource material on former POWs.

There has been a good deal of publicity regarding the ex-POW program and veterans organizations are well aware of the exam program through outreach efforts.

PUBLIC LAW 97-37, P.O.W. BENEFITS ACT AND CIRCULAR 10-83-56, FORT LYON VA MEDICAL CENTER

On receipt of Circular 10-83-56 a renewed effort was made to reach the total P.O.W. population of Colorado. The appointment of Dr. Gaylord Wheeler as our Physician Coordinator and Mr. Donald France as our Administrative Coordinator was our initial step.

The Medical Center with the help of the D.A.V. Association formulated a short letter which was placed in the Colorado D.A.V. Newsletter. In the newsletter we requested all interested P.O.W. to please contract VA Fort Lyon for any assistance we may be able to give and in so doing to especially request the physical examination as published in the Circular 10-83-56. The physical exam date is established at the vets convenience. If the vet accepts he/she is admitted on a short form and a complete work-up is accomplished. We have attended a State Veteran Services Officer Convention, and the Colorado P.O.W. Association, comments from these representatives were," Fort Lyon is doing an outstanding job with the P.O.W. Program". These favorable comments have been made by numerous P.O.W. Vets treated at this Medical Center. We will continue to make our employees aware of the P.O.W. Program and maintain the quality of care required by both the Public Law and the Circular.

RESPONSES TO PREPARED QUESTIONS FROM REPRESENTATIVE HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Will you tell us what plans you have for increased sharing with the military under Public Law 97-174, The VA-Department of Defense Sharing Act?

RESPONSE. Medical District #24 Medical Centers as well as all Medical Districts within Region 5, are actively persuing establishment of formal sharing agreements with local military medical facilities. In particular, VAMC Cheyenne, WY is meeting with the Warren Air Force Base to identify new areas for sharing. VAMC Fort Lyon, CO has recently submitted a proposal to SAC Command for Sharing with Peterson Air Force Base. VAMC Denver, CO has already initiated sharing arrangements with Fitzsimmons Army Medical Center. Additional arrangements are anticipated from other Medical Centers following the VA-DOD Contingency Sharing Workshop scheduled for November 18, 1983 in Salt Lake City.

Mr. **Hammerschmidt.** I noted that you are 9 percent over your estimates for outpatient visits and 12 percent over for inpatient treatment. How are you coping with the obvious budgetary concerns that these figures represent?

Response. I would like to clarify the record with regard to the increased workload percentages identified above. In my written statement dated October 22, 1983 I stated that patients treated were 1 percent and outpatient visits were 7 percent over plan. Region 5 on a whole was 4.8 percent over plan for outpatient visits and .3 percent under plan for patients treated. As Regional Director, I am responsible to insure that direct patient care activities are funded. To accomplish this within the limited resources available it was necessary to reprogram some equipment and nonrecurring construction monies to supplement funding for our Medical Centers.

With regard to Medical District #24 in particular, the District has no problems in maintaining current workloads at this time. They will need to reduce some services if a contingency plan becomes necessary and if funding support is not available. Part of their increased outpatient workload during fiscal year 1983 is attributed to the opening of the Colorado Springs Outpatient Clinic.

Mr. **Hammerschmidt.** The Volunteer Program of the VA adds greatly to the success of its medical activity. Please give us a status report as to this District.

Response. Volunteer programs provide great support and assistance to all VA Medical Center activities within Region 5. With regard to Medical District #24, 2,061 volunteers donated 346,300 hours of service to our Medical Centers in fiscal year 1983. If the total hours donated by our dedicated volunteers had to be performed by full-time staff, an additional 166.5 FTEE would have been required.

Mr. **Hammerschmidt.** In your testimony you mention that 124 research projects are funded for the District. Please tell us something about the type of research that is taking place and tell us how the research program relates to the actual giving of treatment to our veteran patients.

Response. The Medical District supports a variety of Medical Research Programs essential to high quality health care to veterans and all Americans. The Research Program is relevant to several major medical problems including cancer, heart disease, stroke, aging, neurological diseases (spinal cord injury), digestive diseases, pulmonary diseases and metabolic diseases such as diabetes. These high priority medical problems and many others are being attacked with a concerted effort of research, teaching and patient care by a staff of physicians and basic scientists who have joint appointments at VA Medical Centers and Universities.

Mr. **Hammerschmidt.** A recent report by an Association of Orthopedic Doctors who are Chairmen of Orthopedic Surgery at a number of Medical Schools was very critical of VA. The report said, among other things, that equipment often broke down during surgery, funding for Orthopedics was not properly allocated, surgery was often delayed, and that patients stayed too long in hospitals. Would you please comment in terms of this Medical District?

Response. There are no significant problems indicated within District #24 or Region 5 with the exception of VAMC Salt Lake City. VAMC Salt Lake City currently has a 6–10 week waiting list primarily due to budget constraints. Prosthetic divices, especially artificial joints, are extremely expensive and the Medical Center can buy limited quantities within existing resources.

Mr. **Hammerschmidt.** I understand that the Denver Hospital experimented with a laundry technique concerning doing laundry with cold water as opposed to hot water and that it proved that the technique was efficient and that it saved a lot of money. Doing laundry in VA Hospitals is big business. Tell us about the experiment and what do you see as its future?

Response. Recently VAMC Denver conducted a 15-month cold water laundry test. The study methodology examined bacteria concentration after the wash cycle for sheets and towels washed at 72 degrees fahrenheit. The results of this test found that the bacteria levels were acceptable within microbiological/infectious disease standards. The deficiency of the study was that it did not consider linen quality with respect to appearance, whiteness and tensile strength.

Dr. Blaser, Chief, Infectious Disease Section, discussed the results of the study with VACO Building Management personnel. It was his impression that this new technique could save the VA millions of dollars. Dr. Blaser is publishing his study results in the January 1984 issue of the Journal of Infection Disease. It is anticipated that his study will receive wide acceptance from the field and VACO Building Management Service plans to implement cold water washing nationally at several selected laundries after the study receives field acceptance. The long range goal is to eventually convert to cold water washing nationwide.

Mr. **Hammerschmidt**. What is your waiting time for processing admission to the hospitals in the District. Also what is the waiting time at the pharmacies for prescriptions?

Response. The waiting time for processing admissions to the Medical Center ranges from 17 minutes at our smaller facilities to 3 hours at our larger Medical Centers.

With regard to prescription waiting times these range from 15 minutes at smaller Medical Centers to 90 minutes at the larger Medical Centers.

The Medical Centers are acutely aware of these waiting times and are working to reduce them where possible.

Mr. **Hammerschmidt**. In your testimony you mention that you are planning for an increase of 93 percent in the State Nursing Home census in this District. I have felt that this was an excellent Federal-State Program. My question is: Are the States in this District in support of your estimated increase?

Response. I wish to correct my previous statement to read that Medical District #24 is planning for an 83 percent increase in the State Nursing Home program by 1990. This anticipated workload increase has been discussed with and endorsed by the State Veterans Homes within the District.

During the 1983 MEDIPP Planning cycle Region 5 Medical Districts have increasingly recognized the State Vetrans Homes as valuable resources for providing care for our increasing older veteran population. Projected 1990 State Nursing Home utilization is anticipated to increase 17.9 percent over the Fiscal Year 1982 actual census level.

Mr. **Hammerschmidt**. We sometimes hear that some hospitals are not up to date on the VA Policy with respect to Agent Orange Examinations and Treatment. We are told that a lack of concern is sometimes evident and that while the Central Office policy is a good one, that it isn't always properly administered. Would you please comment as to this Medical District?

Response. Medical District #24 has no evidence of negative reports or complaints from VACO or veterans regarding Agent Orange Examinations and Treatment. All Agent Orange Exams and follow-up are being conducted in compliance with VA Policy. It is their experience that the level of new patient applications for Agent Orange Exams are tapering off. In addition, Region 5 as a whole is in compliance with the VA policy for Agent Orange Examinations and Treatments.

Mr. **Hammerschmidt**. What is the Status of Compensation and Pension Physical Exams. Are you current?

Response. Medical District #24 is in compliance with VA standards regarding Compensation and Pension Examinations with the exception of VAMC Cheyenne and VAMC Fort Harrison. Both Medical Centers experienced personnel problems which cause the number of exams processed in less than 30 days to be slightly under criteria. These personnel problems have been corrected and both Medical Centers are eliminating the previous backlog.

Mr. **Hammerschmidt**. What kind of recruitment and retention problems do you have in this Medical District?

Response. Medical District #24 is experiencing difficulty in recruiting and retaining Physical Therapists, Licensed Practical Nurses (LPNs), and Respiratory Therapists. These difficulties are attributed primarily to non-competitive salaries and long lag time in receiving certification from OPM.

For Region 5, the overall recruitment and retention problems have eased somewhat over last year (Fiscal Year 1982). For example, the approval of special pay rates and new classification standards have greatly improved the Medical Center's ability to fill Radiology and Medical Technologist vacancies. The Region as a whole, however, continues to have difficulty in recruitment of specifically Physical Therapists and certain categories of Physicians, Psychiatrists.

Mr. **Hammerschmidt**. The congress is about to give VA the authority to determine qualifications and set the rates of pay for Licensed Physical Therapists, Respiratory Therapists, and Licensed Practical and Vocational Nurses. The Office of Personnel now has this authority. How is this going to help in this area of the country in terms of recruitment and retention of these kinds of employees?

Response. As was addressed in your previous question, Medical District No. 24 is experiencing shortages in LPN's, Physical Therapists and Respiratory Therapists. The authority to determine qualifications and set rates of pay will be of great assistance in the area of eliminating current long lag times experienced in obtaining OPM certification. However, concern is expressed regarding current classification pay levels. Current pay rates will not improve VA Medical Centers ability to compete with the private sector. Unless current pay levels are raised or these categories of personnel are moved to other pay schedules, the pay issue will continue to hinder recruitment efforts.

Within the Region it is anticipated that this authority will provide great assistance to Medical Centers in their recruitment efforts. However, the ability to determine qualifications and set pay rates is only part of the total recruitment problem. Ability to set pay rates will enable Medical Centers to generally keep pace with high private sector pay schedules. A key problem in recruitment, however, is the vast differences in benefits. The private sector generally provides paid health and life insurance and continuing education funding for difficult to recruit personnel.

Mr. HAMMERSCHMIDT. I thank you for that response.

I want to say to those who are not professional executive branch or legislators that we make a public record here, and I think it is important that you all know you have access to that record, and these gentlemen are going to be responding to that question, and this I believe will give you more confidence in the system and we will also have something more tangible to point to.

I have one more question.

Sometimes under the rules you terminate non-service-connected outpatient treatment, including the filling of prescriptions of patients who have been previously hospitalized or previously provided such care.

Can you explain such termination to an elderly veteran who has been receiving such outpatient treatment for a long period of time in a manner that he can understand and accept?

Mr. MULLON. First of all, sir, we don't want to terminate anybody from our outpatient program. In the testimony earlier by Denver, we mentioned that there is very little attempt made at such discontinuance. When a veteran is terminated from the program, he is seen by members of our staff, these members are generally social work employees, social workers who work with him and his family to obtain other care.

We will not abandon a patient. There is no way we will. This is not only against the law, but against being humanitarian in every way. We won't do that. We will find other ways of providing the care for him if we have to terminate.

As you are aware I am sure, Mr. Congressman, there is a law which requires at the end of 1 year we review non-service-connected veterans who are receiving outpatient care. We did not submit that provision to the law. It was passed, however. I am sure that most of the people around this table would support any review of that legislation—I believe it was Public Law 93-82—which limits us in that way. We are bound by that law.

We try, however, in many cases, to find alternatives to that law. If the veteran, for instance, needs to come back into the medical center at the end of a year, we bring him back in, he is seen again, and if he becomes an inpatient, he begins a new 1-year period. This is, in a way, going around the system. But we are not about to eliminate a veteran from outpatient care if we can avoid it. And if there is anything we can do to smooth the transition for him, we do so.

Mr. HAMMERSCHMIDT. Well, that was the type of response I was hoping that we would receive. I think that that word needs to be out among the concerned people. Unfortunately, it is rather confined here today. Nevertheless, it will become part of the public record.

Mr. Mullon. One other thing, if I may, sir.

On the issue of publicity, we are prevented again by law and regulation from publicizing the VA's good things as well as perhaps some of the things we have problems with. We are not allowed to make an issue of our own successes. We look to the service organizations and Members of Congress such as your committee who have been so helpful to us in the past in bringing the word across.

And also reviewing perhaps legislation that prevents us from bringing our own message out in that regard.

We are most appreciative for your patience.

Mr. Edgar. I am not asking you to break the law, but you took an awful lot of pictures on our tour, and my guess is you are going to put those pictures in some public media. You might put in a statement in terms of our visit. There are ways to publicize. I think you can do that—patients can do it in a sense for you, the service organizations can do it.

I think a lot of the media, we had a good representation of the media from Denver here, are kind of hungry to understand what the system is all about. If we have good news we have to tell it, if we have bad news we have to be honest.

I realize there are some prohibitions, but there is a difference between propaganda and public service.

Mr. Mullon. Yes, sir. We are aware of that. We appreciate those comments. It is much better to have someone else blow your horn than yourself.

I would like to introduce one person not introduced earlier: Mr. Charles Beck, the Director of the VA Medical and Regional Office Center in Cheyenne, Wyo. He has a lot to do with what goes on in the State of Colorado and the referral of patients into Denver.

Mr. Edgar. We thank him for his presence today. We invite anyone who has not had a chance to speak to submit for the record their views and comments.

Thank you all for coming today and participating in these hearings. They have been helpful to us in helping to learn how the veterans health care system works. You will hear more about us in the future.

Again I pay special tribute to our ranking representative on the full committee. He has a little better opportunity than I do to whisper into Sonny Montgomery's ear, he sits a little closer to the chairman of the House Veterans' Affairs Committee. He is kind of curious about what we have been doing out in these five field hearings. We are anxious to give him a full accounting.

Thank you for coming.

This hearing stands adjourned.

[Whereupon, at 5:25 p.m., the subcommittee adjourned.]

APPENDIX

Statement of

Alfred P. Galloway

National Senior Vice Commander

of

American Ex-Prisoners of War, Inc.

before

Subcommittee on Hospitals and Health Care

Oversight Hearing

October 22, 1983

Mr. Chairman and Members of the Subcommittee:

I am honored to have this opportunity to appear before a Subcommittee that I feel is truly interested in the views of the American Veteran and on my part, the American Ex-Prisoners of War. And more specifically, the implementation of Public Law 97-37 and V.A. Hospital related areas.

I have received reports from former POWs in Denver on the VAMC here and also from the Dallas, Texas VAMC.

I have visited with patients and former POWs at the Ft. Harrison VAMC in Helena, Montana. Along with another couple, I had occasion to visit this Hospital in August, 1983. After meeting with Hospital Director and Regional Director Frank Caldwell, we were given a tour of the Hospital. One of the things I noticed most was that most of the patients knew Mr. Caldwell and he seemed to communicate easily with them and the Hospital employees.

At this particular Hospital, the former POWs that are being given physical examinations under Public Law 97-37 are being admitted to the Hospital for the necessary exams. As in all cases, there will be one or two that are unhappy, and I found this to be the same there, but the majority were pleased with the Hospital and the care given. We would like to compliment the Director and his staff for the extra effort they have put forth in the area of the physical examinations.

Commenting on the Dallas VAMC, we received good reports on the general treatment given to former POWs. However, I question whether they are fully implementing Public Law 97-37 and are giving any credence to Priority Cards, as I have on record that a former POW was told that they didn't know anything about it and as far as they were concerned, it was first come, first served. Another comment from a former POW was that when he talked with a nurse, she stated, and I quote, "If a man was having a heart attack, would you expect us to take you first?" The POW answered that he would not, but you are taking people with the same problems I have, and they are not service connected. This episode took place in the out-patient clinic and I use this as an example to point out that information from the Administrative level often does not reach the employees.

As for Hosptial patient care, this same POW stated that Veterans come from outside the area because they feel they receive good treatment.

Reports from former POWs concerning the Denver VAMC have made clear that prior to Public Law 97-37, the Hospital care was not of the best quality, however, it has improved. Additional information states there are times when employees are rude, curt, and generally uncaring, and not only the employees, but often the Doctors react in the same manner. I believe that I can not only speak for myself, but for all former POWs, when I say that the majority of us may look in good health, but physically and emotionally, we are not. And we do need more than five minutes, as has been reported, of a Doctors time for him to discover this fact.

Concerning the physical examinations being given to the former POWs at the Denver VAMC, most of the men conceded that it is the most complete and thorough examination they have ever received from the VA Hospital. The Psychiatric exam is another story. For example, one POW states that he waited 2 hours and 45 minutes to see the Psychiatrist. Needless to say, he was upset. And after the interview, he did not feel that the Psychiatrist was interested in the problems of the POW. Most feel that the former POW Medical History form is the best form that anyone has come up with yet - however - 40 years too late as some of the questions asked are absolutely impossible for any human being to answer now with great accuracy, since memory fails after all this time. Plus the added fact, that in order for the POW to survive in an everyday world, they had to push back in their mind the ears of starvation, torture, etc., that they had endured. Now, it is equally traumatic to try and remember those details to ensure that the POW will get proper treatment.

It is reported that any interchange between the POWs and the Hospital Director and Regional Director have been extremely satisfactory.

In conclusion, it is my personal belief that the former POWs question the Hospital care and implementation of Public Law 97-37 because it appears to us that there are various versions of how to comply with Public Law 97-37. Guide lines apparently are sent from the Central Office, everyone reads them and then interprets them in their own manner. Speaking on the new protocal for physical examinations being given to the former POWs as instructed by Public Law 97-37, one hospital will admit the person to the hospital for the period they are being examined, another hospital will utilize fee Physicians to do the examining, while still another will have a nurse practitioner do the examination.

I honestly believe this is one of the bigger problems today, no uniformity, and when that is the case, many former POWs will suffer as a consequence.

I also firmly believe that the Psychiatrists must be made aware of our great need for their expertise. Most former POWs find it difficult to relate to a Psychiatrist or Psychologist, but we all are aware that we are exhibiting latent symptoms that are due to our period of incarceration. We are nervous, short tempered, and short on patience by this time. It must be recognized that the former POWs in most cases have waited patiently for nearly 40 years, have participated in medical research, and have supported legislation which may benefit not only them, but all Veterans. Many have hoped that Public Law 97-37 would be a cure-all for the POW, but the Hospital care and Health Care is only part of the picture. It will not be known whether the Hospitals are really fulfilling their part of implementing Public Law 97-37 until reports come from the Rating Boards. I have heard many times, if the Doctor doesn't write it down, we cannot rate. I have also heard Doctors say that if you don't use the right term, even if it is written in the medical record, the rating boards still will not recognize the medical record.

Concerning the Priority Cards, I feel that all that has been reported indicates there is a great need for a definite policy statement - a uniform statement that would be used in all Outpatient Clinics throughout the United States. It should be made known how the priorities work, are the Veterans with service connected disabilities being treated before the non-service connected Veteran or is this method only used when the Budget demands that hospital and health care be cut to the Veterans as a whole?

In closing, may I once again say Thank You for the privilege of addressing this Committee, and testifying for the American Ex-Prisoners of War.

DISABLED AMERICAN VETERANS
DEPARTMENT OF COLORADO

TESTIMONY PRESENTED TO THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS AFFAIRS

DENVER, COLORADO
OCTOBER 22, 1983

DEPARTMENT COMMANDER
McKINLEY NORMAN

Testimony to the SubCommittee on Hospitals and Health Care

Mr. Chairman and members of the SubCommittee, I appreciate this opportunity to appear before you today representing the Colorado Department of the Disabled American Veterans.

As you are aware, the Veterans Administration (VA) hospital and health care system is unique as compared to any other health care delivery system in the United States. This system was established to take care of those who served in this country's armed forces and, by law, focuses its attention on those who were injured or who had injuries aggravated during their service to this country.

As of September 3, 1982, there were approximately 28,522,000 veterans alive, of which 3,422,648 (12%) are at an average age of 65 years or older (1982 Annual Report, Administrator of Veterans Affairs, Table 3, Page 147).

Senate Committee Report No. 12, "A Report on the Aging Veteran, Present and Future Needs" projects that by 1995, in a little over a decade, there will be over 8 million veterans who are 65 years or older (P. viii). This will amount to an increase of 234%.

By the year 1990, veterans are projected to make up 60% of the male population over age 65 years (Table B-7, P.20).

As of September 30, 1982, there were approximately 407,000 veterans in Colorado (143,000, 35% served during W.W.II) of which over half live in the Denver Metropolitan area (1982 Annual Report of the Administrator of Veterans Affairs, Table 1, P. 145).

For the above reasons we are pleased to see the Committee focus on health care needs of the aging veteran. Not only are the infirmities of age debilitating but they also inflame the damage created from existing disabilities.

As the veteran ages, the V.A. Medical Centers will find themselves treating patients who are ill more frequently, who will present more complex medical problems, and who will require a longer treatment period.

We applaud the medical research provided by the V.A. health care system which has not only benefited those with war wounds and other service related injuries, but which has also extended into improved medical care for handicapped people and, finally, the population at large. We encourage the V.A. health care system to continue and to increase its attention on the health care needs of aging veterans.

In the same breath, we urge the U.S. Congress to recognize that the increased care needs of our more senior veterans will increase the pressure on a system already finding it difficult to meet the demands of its veteran patients. It is unconscionable to tell younger veterans that their health care needs cannot be met because the system must now be attuned to the majority veteran need. The system must be able to meet the challenge of serving all of its eligible veterans, older and younger.

You must know that we are grateful for the VA health care system and depend on it for our health care needs. In support of the Denver VAMC, 50 DAV volunteers donated 6,962 hours during the period October 1982 through August 1983. During our 63rd Annual Convention our chapters and department reported donating items and money for a total value of $12,258.96.

We wish to stress that we consider the patients at the Denver VAMC as our members and comrades and the medical center as our own. For these reasons, we are sometimes critical of the VAMC as we would be of a family member, but we are critical with the hope that the criticism will result in positive changes.

I. Operations and Fee Section Needs Access to TARGET Computer

We would note that the Operations and Fee Section of the Denver VAMC still approves, by hand, payments to private physicians submitting charges under fee-basis or structured authority. Periodically we receive complaints about the length of time it takes the V.A. to pay these charges. We urge the V.A. to consider placing a TARGET computer terminal at the VAMC so eligibility determination can be made at the VAMC. The VAMC now refers eligibility questions to the VARO, thereby lengthening the time to make payment. Additionally, unauthorized treatment takes months to get payment. Attachments number 1 and number 2 shows that a physician submitting a bill in February 19, 1983, was still not paid until some time after August 11, 1983.

We believe that failure to pay private physician's charges in a timely fashion will make the private physician hesitant to treat veterans who receive reimbursement on fee basis or structured authority.

II. Pharmacy

In the past, there have been considerable problems with the pharmacy. Those problems have included such issues as a 3-4 hour wait for prescriptions, improper prescriptions, etc. We are pleased to acknowledge that prescription dispensing time is now approximately an hour and we are informed that the hospital Director has instructed the pharmacy to improve on that. Consumers that we contacted indicated that improper prescriptions were not now a problem.

As we made a number of calls to see what the experience of others had been with the pharmacy, one employee's name came up time and time again. We want to point out that very nearly every person we talked to referred to a lady named Francine. Each person we talked to was so complimentary of Francine's work that we wanted to recognize her. Thank you, Francine.

III. Handicap Hiring Practices at Denver VAMC

A critical factor in any hospital is morale. We believe that an important factor in morale is the personnel practice, beginning with the taking of an application. We believe that when an unfair or illegal practice occurs, not only does it affect the individual involved, but tends to cause every other employee to question what may occur to them. For the above reason we bring you three incidents that, based on the Hospital's attitude in addressing them, we believe are characteristic of the Hospital's approach to resolving these kinds of questions.

A disabled veteran who was rated at an amount greater than 30% was told that the Denver VAMC would not accept his employment application until he had submitted a copy of a physical examination performed by his personal physician or the personnel physician for the Denver VAMC. Additionally, although there was no history of a mental health problem, he was scheduled for a mental health examination. We were told by Dr. Oboler, the Denver VAMC Personnel Physician, that the mental health examination was scheduled simply because the applicant was rated 30% or more disabled. Doctor Oboler also indicated that this was a new policy and that two other applicants had also been scheduled for mental health examinations for the same reason (attachment #3). Later we were informed that Dr. Oboler, without authorization of the applicant, had requested and received this veteran's complete V.A. patient records. Dr. Oboler was not seeing the applicant as a patient.

Attachment #4 is a letter from the Medical Center Director requesting information from the V.A. Central Office regarding the Denver VAMC employment practices. Attachment #5 indicates that Central Office did not approve of the Denver VAMC hiring practices.

We wish to acknowledge the fact that the Medical Center Director did modify the Denver VAMC hiring practices following our meeting with him on June 23, 1983, and continued the modified hiring practices contingent upon the Central Office response.

We continue to be concerned that the Medical Center Director claimed that the Denver VAMC hiring practices, prior to their amendment, were the same for other VAMCs. We've seen no effort by the V.A. to determine whether the Medical Center Director's statements are correct or not.

Because of the method by which this matter was addressed by the Denver VAMC we were forced to assist the veteran in filing an Equal Employment Opportunity, Handicap Discrimination complaint which has now gone formal. Although this veteran has been a career civil service employee since the 1950s, the Denver VAMC refuses to hire him except on a temporary basis because of his disabilities.

Another disabled veteran, a nurse, was called in to her interview for a nursing position at the Denver VAMC. Her name came from a certificate drawn from an Office of Personnel Management register.

Following her interview, the individual with hiring authority -- without benefit of a physical examination -- decided not to hire the applicant because she felt that the applicant's service connected disability would not allow her to perform her job. The applicant, in fact, had 12 years experience, including her army nurse training, and performed her duties as a nurse for several years in the army following her discharge with the disability.

Following the filing of an Equal Employment Opportunity, Handicap Discrimination complaint, the applicant was hired and the E.E.O. case resolved.

In our final example, a veteran, service connected for deafness, was a pharmacist with 20 years experience and was hired at the Denver VAMC. Because the pharmacist was deaf a number of problems arose affecting his training in VAMC procedures and he was unable to discuss prescriptions over the phone with the prescribing physician. He was finally terminated because of a number of problems arising out of those difficulties.

Our concern about this matter is that the Denver VAMC has no way to communicate by telephone with its deaf employees or patients except through a third party. Phone equipment is readily available and is comparatively inexpensive. There is already equipment available in the VA system which would allow a deaf employee to use a teleautograph machine and hand write out and receive hand written communications from different places in the hospital.

To the best of our knowledge the VAMC never considered our recommendation.

We believe that these examples are not unique. We also believe that these kinds of issues not only affect the employee in question but cause co-workers to question the fairness and good faith of the personnel practices of the agency.

IV. VA Veterans Outreach

As you are aware, the D.A.V., as always, supported the VA Veterans Outreach program. We continue to do so.

In large part our support is based on our own experience as we initiated DAV outreach centers which were based on the "Forgotten Warrior Project" study conducted by Cleveland University and was funded by the national office of the DAV.

We take a great deal of pride in the initiative shown by the DAV Outreach program in Denver and in the Denver mental health professionals who have been recognized as doing so much locally and nationally to develop treatment modalities for post traumatic stress disorder. These mental health professionals who have already given so much continue to do so.

With that background, we offer the following testimony which will be critical of the V.A. Veterans Outreach program.

I. We question the awarding of contracts in the commuting area of a VAMC or an outreach center except as those contractors are needed to treat patients who cannot get treatment in a V.A. facility. If the information we've received from the Denver VA Outreach program is correct, the law prohibits the use of the contract dollars in the maintenance of the outreach centers or its satellites. We are also told that there are not enough VA staff available to meet the veteran patient's needs. We believe this inflexibility creates a situation where the VA Outreach Centers are overloaded. Thus, contract care is used where VAMC's and VA Outreach Centers are within commuting distance.

II. In some cases, in Colorado (Grand Junction VAMC), VAMC's are not leading therapy groups after contracts are let in their area. Thus, the contracts, in some cases appear to reduce the interest in VAMC's providing treatment provided by the contractors. It should be noted that the Grand Junction VAMC did lead therapy groups some months prior to the letting of the contract in their area.

III. A broader concern is that we do not see the treatment experiences of the V.A. Outreach storefronts being incorporated into the Denver VAMC.

It is as though we are looking at two different agencies who have staked out different turfs and jealously guard them to the potential detriment of the patient.

While we continue to support the storefronts away from the VAMC's and seek continuation of the contract program in a modified form, we believe that the VAMC's must become responsible for these programs if they are to be continued beyond the next few years.

V. Parking

Patient parking has been a problem for years at the Denver VAMC.

For example, prior to beginning recent construction the Denver VAMC had only 456 parking places. After construction the number of permanent parking spaces will be reduced to 358 -- a loss of 98 spaces. At the same time however, the staffing will increase from 1142.7 FTEE to 1370 FTEE following construction. Additionally, patient visits are projected to increase by approximately 40,000 from 139,782 actual outpatient visits in fiscal year 1983 to 179,000 outpatient visits in fiscal year 1986, at the end of the construction.

Compounding the problem is the fact that this VAMC is constructed in a residential area that has about six major hospitals in almost as many blocks.

At this time, many hospital visitors and patients must park blocks away from the hospital in front of a residence and walk or be pushed in a wheel chair to the hospital.

It is not at all clear how employees handle this problem as there is a two hour limit on street parking or metered parking to reduce the parking congestion in this predominantly residential area.

When we called the Medical Center Director's office about this issue for our testimony he said that the Denver VAMC will require 994 parking spaces according to the VA planning criteria for VA facilities. And such planning has been put into the Hospital's five year plan -- planning through fiscal year 1988. However no funding has been allocated for such a project and obviously the parking problem exists now.

VI. Nursing Home Beds

We were pleased to be informed that the new Denver VAMC construction will include approximately sixty nursing home beds.

While Colorado now has two state veterans nursing homes partially funded under 38 USC Section 5035 and a third now being considered, because of the certificate of need process in Colorado, we are unable to get such a facility built in Denver where over half the veterans live.

As I'm sure you're aware, veteran's incomes -- frequently because of their entitlement as veterans -- often are medically indigent for for nursing home care because their income exceeds the Medicaid limit but does not allow them to meet private nursing home costs. Additionally, the spouse frequently may have to enter a nursing home, not because he or she requires it, but all other income goes to keep the veteran spouse in a nursing facility. Obviously the money paid by the VA under authority of 38 USC Section 641 can substantially change these circumstances.

The Denver VAMC has two additional complicating factors. First, the State of Colorado has done away with the "Medicaid spend down program" which would allow Medicaid recipients to subtract certain costs -- such as medical expenses -- from their income, allowing people who otherwise would not qualify for Medicaid to qualify. Second, we are informed that for non-service connected disabled veterans who are being placed out of the Denver VAMC on nursing home contracts, that while the contract can be six months long, the Denver VAMC will approve a three month contract immediately, but is very restrictive in extending the contract to six months although the veteran may still require nursing home care.

We recommend the following:

1. Continued and increased federal funding for 38 USC Section 5035 to reduce the backlog of applications. States now have to wait years before their application can be funded.

2. Amend 38 USC Section 5035 to provide for grants for up to 65% of cost of acquisition and/or remodeling of existing nursing home facilities to allow their conversion into a state veterans nursing home. Such an amendment would allow the purchase of a nursing home in the Denver area for conversion to a state veterans nursing home.

3. Cause the Denver VAMC to more liberally administer the nursing home contract care program and the Congress and VA Central Office to allocate additional funding for such services in the Denver area.

VII. Denver VAMC Waiting Area

We are pleased with the new construction going on at the Denver VAMC and so therefore do not wish to be unnecessarily critical of the inconvenience that cannot be avoided.

However, one area of concern is the waiting area. Because of the number of outpatient visits and the nature of the VAMC's it is frequently necessary to wait for extended periods. We are informed that, particularly on Wednesdays and

Thursdays, there is just not enough waiting area, requiring patients to stand until they can be seen. We urge that this be taken care of.

VIII. VA Response to Inquiries and Representation

We have directed inquiries to the VA requesting information about specific patients and general inquiries about policy and data which have gone unanswered.

Obviously, we hold ourselves out to represent veterans regarding issues that may affect them. The law also authorizes us to do this within the Veterans Administration system. However, when the VA fails to answer or answers our inquiries late, our ability to represent individual veterans or veterans concerns is severely impacted.

The problem has reached such a level of concern that we are informed that our National Service Officers put virtually everything in writing when requesting information from the Chief of Medical Administration, Denver VAMC. While there has been some improvement, even so, they have continued to express concern about the poor response or no response at all.

Another example is correspondence we sent to Readjustment Counseling Service, Mr. Ed Lord, VA Central Office. Although the letter was sent in April and follow-up phone calls elicited answers that a response was forthcoming, no answer has yet arrived.

During the week of October 10, 1983, a call to the office of the Administrator of Veterans Affairs has elicited, once again, a promise to respond shortly. We are more confident of the last offer to answer our April inquiry, even though it is over 7 months following our initial inquiry.

Thank you for inviting us to appear before you today. We appreciate your interest in our views.

Attachment #1

FAMILY PHYSICIANS
2520 16th Street
Greeley, Colorado 80631
(303) 356-2520

T. E. Baldwin, M.D.
Jack Berry, M.D., P.C.
Charles C. Chesley, M.D.
Robert P. Gentry, M.D.
Kenneth M. Olds Jr., M.D., P.C.
Charles E. Westrup, M.D.

3-23-82

Mr. Robert Davis
Veterans Advisor
Weld County

Re:

Dear Mr. Davis,

I am in receipt of the VA's form letter denying of the payments for his hospitalization. In fact was admitted to the hospital with status epilepticus which does constitute an emergency. It is my opinion that delay in hospitalization would have been hazardous to his health and life. That very afternoon that I hospitalized him, I did call the VA hospital in Denver to talk with who is the neurologist that approves hospitalizations for .. I was informed that Friday afternoon was afternoon off and talked to the VA person that was handling phone calls. I was told that the person who was covering for would get back in touch with me but never did receive such a phone call. When arrived back to work on Monday, I did discuss the hospitalization with and received assurance that this would be treated as a medical emergency. was already out of the hospital at that time, and I did inform of that fact as well.

If there is any further way that I can clarify this for the VA, please let me know.

Sincerely,

Kenneth M. Olds, M.D.
KMO:lc

Attachment #2

Medical Center

1055 Clermont Street
Denver CO 80220

Veterans
Administration

August 11, 1983

In Reply Refer To:

Department of Veteran's Services
313 N. 11th Avenue
P.O. Box A
Greeley, Colorado 80632

Dear Sir:

This is to inform you that we have received your billing for services rendered to ________________________ on February 10, 1982. We do not have any records to identify this patient as a veteran. As soon as we establish his eligibility, we will notify you if the bill is approved or disapproved for payment.

Under the provisions of the Prompt Payment Act; we are required to inform the vendor when we cannot immediately process a bill for payment.

Sincerely yours,

LYLE K. DURBIN
Chief, Medical Administration Service

Attachment #3

DAV
DISABLED AMERICAN VETERANS
DEPARTMENT OF COLORADO
PHONE 922-3831
1400 SOUTH FEDERAL BOULEVARD
DENVER, COLORADO 80219

June 28, 1983

Mr. Carlton Smith
Hospital Director
Denver V.A. Medical Center
1055 Clermont
Denver, Colorado 80220

Dear Mr. Smith:

Thank you for honoring our request for a meeting on June 23, 1983 in your office. That meeting included you, Mr. Phil Varnak, your Personnel Director; Mr. Jerry Steelman, DAV National Service Officer; Ms. Michelle D'Arcy, Department Advocate Trainee; and myself.

We brought the following concerns to you:

1. Mr.   , a veteran with a V.A. service connected disability rated greater than 30%, was required by Dr. Obler, V.A.M.C. Personnel Physician, to take a mental health examination simply because he was a disabled veteran who had a V.A. service connected disability rated greater than 30%. (Attachments #1 and #2)

2. Dr. Obler, Ms. Walker, Secretary to Mr. Varnak; and Ms. Shirley Thomas, Personnel Management Specialist Trainee had confirmed the statements of Mr.   . This confirmation occurred prior to our June 23, 1983 meeting. Dr. Obler had indicated to me that this was a new policy and had been invoked against three disabled veterans.

3. A Denver V.A. Medical Center memorandum from Personnel to Personnel staff, dated February 7, 1983, Subject: Policy Memo #50 - Determining suitability for federal employment - (correction) (attachment #3). That memo in part 2.C states:

   > "All applicants with mental and/or physical disabilities must be examined and recommended for employment by the VA physician or the applicant's physician before his/her application is considered for the applicant supply file."

"To aid and assist worthy war-time disabled veterans, their widows and orphans"
(From the D.A.V. Constitution Preamble)

4. The fourth item covered the question as to whether or not V.A. employees could be represented by the Disabled American Veterans regarding issues that might arise at the V.A.M.C. I believe that we all agreed that the DAV did not desire nor did the bargaining unit grievance procedures or issues arising out of the V.A.M.C. compliance with the union contract allow DAV involvement, that the DAV could represent employees regarding equal employment opportunity issues and that the DAV would contact the hospital director in the case other issues arose. We appreciate your willingness to clarify my position as a DAV employee with the V.A.M.C department chiefs.

5. We asked if V.A.M.C. medical records are routinely reviewed if a veteran should apply for employment at the V.A.M.C. following their having received treatment at the Denver V.A.M.C. Neither you nor Mr. Varnak knew the answer to this question although you offered us an answer in writing at a future date.

We argued then and now that 29 CFR 1613.706 (attachment #4) prohibits singling out handicapped people for routine physical examinations. We contend that physicals must be given to all applicants or only to those where accommodation needs due to physical and mental handicaps have been identified.

We believe that 29 CFR 1613.706 prohibits the requirement in the aforementioned V.A.M.C. memorandum which requires handicapped applicant's applications from being considered until their physical and mental conditions have been evaluated by a physician. We noted your comment that this is a common requirement in V.A. Medical Centers throughout the nation.

While you indicate that service connected disabled veteran's employment applications are not treated any differently than any other application and that psychological examinations are not routinely scheduled if their disability ratings exceed 30%, I remind you that Dr. Obler indicated that he required three such disabled veterans to take psychological examinations. One such veteran was Mr. . Why was Mr. scheduled for a psychological examination? Please review the other two instances referred to by Dr. Obler.

We appreciate your offering to have the aforementioned V.A.M.C. personnel memo reviewed by the General Counsel and personnel specialists at the V.A. Central Office in Washington, D.C. We appreciate your offer to send us a copy of that letter.

Sincerely,

Lennox E. Gilmer (MD)

Lennox E. Gilmer
Department Advocate

cc: Mr. Harry N. Walters
Mr. Norman Hartnett
Mr. Jerry Steelman

DISABLED AMERICAN VETERANS
DEPARTMENT OF COLORADO

LENNOX E. GILMER
Department Advocate

Headquarters:
1400 S. Federal Blvd.
Denver, CO 80219
(303) 922-3821

Name

Date: JUNE 22, 1983

Address

C File Number

City: AURORA, State: COLORADO Zip: 80012

Social Security No.

Phone Number

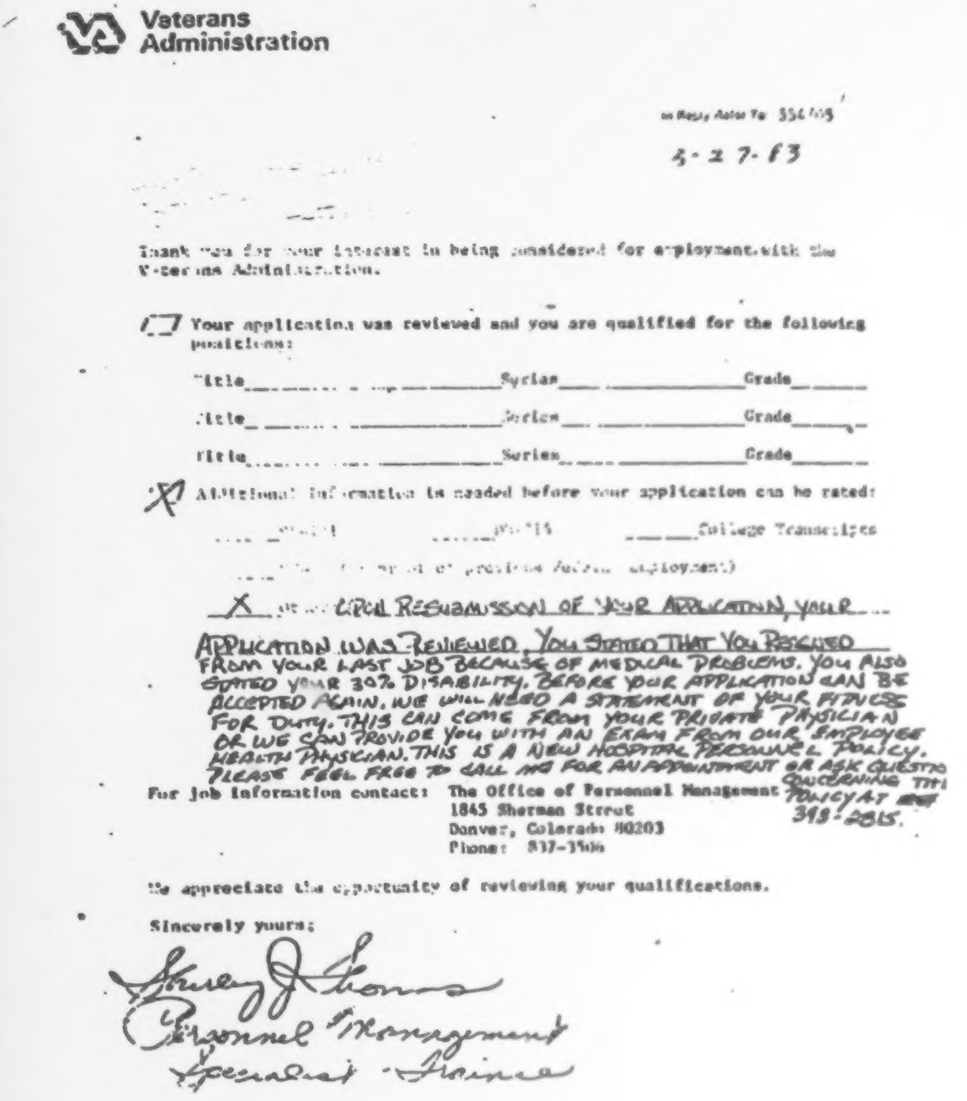
I the above identified individual do request that Mr. Lennox E. Gilmer, Department Advocate, Disabled American Veterans, represent me.

He is to be given access to all pertinent documents including personnel records, medical records, and any other records within the limits of the law.

Mr. Gilmer will represent me in the below listed matter:

MY APPLICATION FOR EMPLOYMENT AT THE DENVER V.A. MEDICAL CENTER.

Sincerely,



Veterans
Administration

In Reply Refer To: 556/05

5-27-83

Thank you for your interest in being considered for employment with the Veterans Administration.

☐ Your application was reviewed and you are qualified for the following positions:

Title________________Series________________Grade______

Title________________Series________________Grade______

Title________________Series________________Grade______

☒ Additional information is needed before your application can be rated:

____ [illegible] ____ [illegible] ____ College Transcripts

____ [illegible] of previous Federal employment)

X [illegible] UPON RESUBMISSION OF YOUR APPLICATION, YOUR APPLICATION WAS REVIEWED. YOU STATED THAT YOU RESIGNED FROM YOUR LAST JOB BECAUSE OF MEDICAL PROBLEMS. YOU ALSO STATED YOUR 30% DISABILITY. BEFORE YOUR APPLICATION CAN BE ACCEPTED AGAIN, WE WILL NEED A STATEMENT OF YOUR FITNESS FOR DUTY. THIS CAN COME FROM YOUR PRIVATE PHYSICIAN OR WE CAN PROVIDE YOU WITH AN EXAM FROM OUR EMPLOYEE HEALTH PHYSICIAN. THIS IS A NEW HOSPITAL PERSONNEL POLICY. PLEASE FEEL FREE TO CALL ME FOR AN APPOINTMENT OR ASK QUESTIONS CONCERNING THIS POLICY AT [illegible] 393-2815.

For job information contact: The Office of Personnel Management
1845 Sherman Street
Denver, Colorado 80203
Phone: 837-3506

We appreciate the opportunity of reviewing your qualifications.

Sincerely yours;

Shirley J. Thomas
Personnel Management
Specialist - Trainee

Veterans
Administration

Memorandum

Date: February 7, 1983

From: PERSONNEL OFFICER (05)

To: PERSONNEL STAFF

Subj: Policy Memo #50 - Determining Suitabilit
for Federal Employment - (Correction)

1. **PURPOSE:**

All applications must be screened for suitability determination before being accepted for the applicant supply file to insure proper selection for safe and efficient work performance.

2. **POLICY:**

A. Employees removed by an agency may apply to OPM for a determination of suitability for further employment in the competitive Federal service. After appropriate consideration, if found unsuitable, OPM may cancel reinstatement eligibility or prescribe a period of debarment not to exceed three (3) years.

OPM may make a determination of suitability upon receipt of an official request from an interested agency provided the employee has basic eligibility for reemployment. (FPM 731, subchapter 4.)

B. Determination of suitability for applicants who were "fired" from private industry will be at the discretion of the examining Personnel Management Specialist. The Specialist will alert the selecting official upon referral.

C. All applicants with mental and/or physical disabilities must be examined and recommended for employment by the VA physician or the applicants physician before his/her application is considered for the applicant supply file.

PHILIP A. VARMAN

*Disregard previous Policy Memo #50, dated January 27, 1983 and replace with the above.

cc: Len [illegible] [illegible]

Marvin N. Cameron, M.D., P.C.
3431 SO. CHAMBERS ROAD
AURORA, COLORADO 80014
383-7908

6/15/82

To whom it may concern:

is in good condition for clerical work. He can do moderate (30 to 50 lbs.) lifting and moderate standing.

He has always appeared very emotionally stable.

Sincerely,

Marvin N. Cameron M.D.

Attachment #4

Denver CO 80220

Veterans
Administration

JUN 27 1983

In Reply Refer To: 554/05

Asst. Deputy Administrator
  for Personnel 10BA5/05C
VA Central Office
810 Vermont Avenue N.W.
Washington, DC 20420

SUBJ: Advice On Pre-employment Medical Determinations

1. In administering our applicant supply files, we have established a policy which requires medical determination for applicants who indicate on their SF-171 that they have had physical or mental problems in the past. In any cases where this is indicated on the SF-171, we request that the personnel physician do a medical evaluation to determine if the applicant meets the medical qualification for the position. This determination is made prior to entering the applicant in the applicant supply file.

2. On June 23, 1983, we met with representatives of the Disabled American Veterans who do not feel this policy is appropriate. They provided us with a copy of the Code of Federal Regulations, Section 1613.706(b) which forms the basis for their opinion. We do not concur with their position in that the Federal Personnel Manual, chapter 339 establishes in subchapter 3, that we may obtain medical evidence and act on that medical evidence prior to appointment in any cases where the appointing officer questions the ability of an applicant to perform a position because of medical reasons. Furthermore, we feel this is appropriate under section 1613.706(a) of the Code of Federal Regulations cited above. This discussion arose because of a recent case involving an applicant, Hiram D. Gibson, who indicated on his application for federal employment that he left his last clerical position because he could not physically perform the duties of the job. A copy of Mr. Gibson's application is enclosed for your review. In this case, Personnel Service requested that the personnel physician conduct an examination to determine if Mr. Gibson was physically qualified to perform the duties of a clerical position for which he was applying. This request was made prior to entering Mr. Gibson in our applicant supply file.

3. Since we disagreed with the Disabled American Veterans representatives on the interpretation of the Code of Federal Regulations, and they disagreed with the procedures we were following, we agreed to forward this to VA Central Office for review of appropriate personnel representatives and/or General Counsel to determine if the procedure we are following is appropriate. Your assistance and advice on this matter will be greatly appreciated.

CARLTON M. SMITH
MEDICAL CENTER DIRECTOR

cc: Disabled American Veterans ✓

Attachment #5

Medical Center

1055 Clermont Street
Denver CO 80220

Veterans
Administration

AUG 3 1983

In Reply Refer To: 554/05

Mr. Lennox E. Gilmer
Department Advocate
Disabled American Veterans
1400 South Federal Boulevard
Denver, CO 80219

Dear Mr. Gilmer:

We have received a response to our letter of June 27, 1983, from VA Central Office concerning the advice we requested in regard to our policy on Pre-employment Medical Determinations. This letter was sent in response to the meeting I had with you and your representatives on June 23, 1983.

In accordance with the advice rendered in this letter from our Regional Director, we have discontinued the practice of obtaining medical determinations prior to entering applicants in the applicant supply file. In the future, all eligible applicants will be entered in the applicant supply file and pre-employment determinations will be made only after they have been tentatively selected for employment.

I believe this resolves the last of the issues raised in our meeting.

Sincerely,

CARLTON M. SMITH
Medical Center Director

cc: Dr. Oboler (11B)
Mr. Jerry Steelman

STATEMENT OF
BRENDA E. VAN ANTWERP
DEPARTMENT SERVICE OFFICER
THE AMERICAN LEGION, DEPARTMENT OF COLORADO
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERAN AFFAIRS
OCTOBER 22, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 20,000 members of The American Legion, Department of Colorado, I wish to thank you for inviting us here today to express our views on Veterans' Administration (VA) health care, as represented in the Denver metropolitan area.

The American Legion would like to point out that the veterans of Colorado are very fortunate to have three (3) Veterans' Administration Medical Centers (VAMC). As you know, Colorado is geographically divided by the Rocky Mountains, and the fact that the VA has taken this into consideration in their past planning, by placing a VAMC on the western slope, one in southern Colorado, and one here in Denver, is greatly appreciated by the veterans of this state. This planning on the part of the VA has provided most veterans in our state access to a VAMC near their community.

PARKING

I would like to now address the most obvious problem of the Denver VAMC. Because this hospital is landlocked and because the hospital is currently under construction, parking spaces are minimal. Although we expect this situation to improve after construction is completed, adequate parking is not going to be available even at that time. There simply is no space. We would ask this Subcommittee to seriously consider funding for a high rise parking lot for the Denver VAMC. While parking lots in and of themselves are not part of health care issues, we certainly feel that inadequate parking could affect health care in that aged, severely disabled, and seriously ill veterans may not be able to obtain health care simply because they will not have easy access to the hospital. In addition, frequent and large snowfalls and temperature changes make adequate and nearby parking a necessity in this area of the country.

AGING VETERANS

There are over 400,000 veterans in the state of Colorado. Approximately sixty percent (60%) of these veterans live in the Denver metropolitan area. The Denver VAMC provides health care for a large number of these veterans, and many have service-connected disabilities. Because of the large number of service-connected veterans seeking treatment at this hospital, it is very difficult for a veteran with a nonservice-connected disability, even one who meets the eligibility requirements set by Congress, to obtain outpatient treatment from our VAMC. Also, due to the budget restraints at the state and local levels, many veterans who previously sought treatment at Denver General Hospital or the University of Colorado Medical Center are being referred to the Denver VAMC. In turn, because of limited resources, the VAMC is unable to meet the needs of these veterans.

The American Legion is in no way suggesting that the current priority system for health care treatment be changed. However, we are concerned that as the veteran population continues to age, their numbers will further tax the resources of the VA. Inevitably, many veterans, who have never used VA services, will seek to do so as they get older, experience more health problems, and are forced to live on reduced and fixed incomes. We are aware that the VA has already undertaken a number of initiatives to begin to provide care for older veterans. For instance, ground has recently been broken for a sixty (60) bed nursing home unit as part of our VAMC. We are supportive of these measures and would ask that this Subcommittee continue to insure that the VAMC has adequate funding for these and other measures.

PSYCHIATRIC CARE

It is our feeling that one of the major problems at the Denver VAMC is the quality of psychiatric care. Mr. Chairman, in May of this year, two veterans, both represented in their efforts to obtain VA benefits by the American Legion, attempted to commit suicide at the Denver VAMC. One veteran died as a result, the other veteran is now a high level quadriplegic. The deceased veteran was an outpatient at the VAMC and was evaluated within minutes prior to his death as not needing hospitalization, nor was he considered to be a danger to himself or to the community. The second veteran was being held on a locked ward, and while in his room, managed to break through a suicide prevention screen (a task that is estimated to take more than one half hour - all without alerting anyone on the VAMC staff) and leap from the seventh floor of the hospital.

In addition, in the last few weeks, a veteran was placed in the VAMC on 180 day hold and treatment. This veteran was allowed to walk away from the VAMC and no one from the VAMC sought to locate him. His bed was held for one day and then he was decertified. He subsequently murdered two members of his immediate family. These tragic deaths and serious injury, raise serious question in our minds as to the quality of care provided by the psychiatric program at the Denver VAMC.

A related problem here in Denver is the evaluation and diagnosis of Post Traumatic Stress Disorder (PTSD) during disability evaluation examinations for compensation purposes. For example, although the veteran exhibits symptoms such as recurrent dreams about being killed in Vietnam, startle response, limited social or interpersonal relationships, etc. etc., the examining physician arbitrarily states there is no evidence to support a diagnosis of PTSD. While we realize that the adjudication of PTSD claims by VA regional office rating Boards is not under consideration during this hearing, there is a relationship between the disability examinations and the rating of these cases. We feel this is a serious situation and we have developed a number of cases wherein problems concerning the diagnosis and/or rating evaluation exist. We have forwarded these cases to our National office for presentation to the proper VA officials.

In addition, through our National office, we have asked that Dr. Donald Custis, Chief Medical Director, provide a Medical Inspector General to investigate the quality of care at this hospital. Mr. Chairman, we respectfully request that this Subcommittee require the VA to investigate these conditions. However, we do not wish to totally condemn all of the psychiatric services provided by the Denver VAMC, and with this in mind, The American Legion, Department of Colorado, would like to express our gratitude to the VA and the Subcommittee for providing adequate funding in Colorado for the contract psychological counseling program for Vietnam veterans.

While The American Legion has supported the concept of the Vets Centers and contract care from the beginning, we in Colorado consider ourselves most fortunate in having a nationally recognized expert in PTSD, providing contract psychological care to our veterans. We would like to commend Dr. Tom Williams and other contractors in the Denver metropolitan area for the outstanding services provided to veteran clients of The American Legion. We would also like to thank the VA for expanding the contract care program into remote and outlying areas of Colorado.

We recognize that one of the reasons for establishing Vets Centers and contract counseling was based on the fact that many Vietnam era veterans objected to the administrative red-tape at federal facilities. It is our belief that these objections will not soon subside. For this reason, and because of the excellent services received through contract care here in Colorado, we strongly urge the Subcommittee to continue funding for this significant program. As a Service Officer, I have referred many veterans to contract care providers, and in my opinion, this program has worked and worked well for my veteran clients.

This concludes my statement, Mr. Chairman. Thank you for allowing us to express our views on these issues.

Psychotherapy & Biofeedback Associates
1630 25th Avenue, Suite H
Greeley, CO 80631
(303) 353-6552

NAM-VET COUNSELING PROGRAM
Robert W. Stewart, EdD
Director

Susan Spilman, PhD
Joyce Shohet Ackerman, EdD
Susanne Ferril, MA

October 22, 1983

TO: SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

TESTIMONY: READJUSTMENT COUNSELING FOR VIETNAM ERA VETERANS BY CONTRACT PROVIDER

Program Description

The Nam-Vet Counseling Program opened full-time offices in Greeley (Weld County) on April 25, 1983. A part-time office was opened in Ft.Morgan (Morgan County) on September 2nd. Four therapists provide services to Vietnam era veterans and their significant others through individual, couple and group counseling.

Population Served

According to the Colorado Veterans Affairs Office, the number of Vietnam era veterans living in the area served by our program include: Weld County--5,290; Larimer County--5,500; Morgan County--850; Logan County--9[illegible]

Program Work Load

The program agreed to provide up to 32 sessions per week of individual counseling and up to three sessions per week of group counseling. We were providing 40% of our maximum individual sessions by August and will be providing approximately 75-80% of that maximum by the end of October. In addition, we will be providing two groups per week by the end of October.

The number of individual sessions doubled from the first month of service to the fourth month and doubled again by the sixth month. We currently have 35 active clients,and we project that we will be at maximum capacity before the end of the present calendar year.

Effectiveness

This program and the other services offered through the Denver and Cheyenne Outreach Vet Centers are the only outpatient services most of the veterans in our area will use. VA Hospital outpatient services are avoided because of being too inconvenient and being too closely associated with the government and bureaucracy. Mental health centers are avoided because of perceived insensitivity to Vietnam veterans. Hallmarks of the Vietnam era veteran in trouble are alienation and withdrawal into isolation. They require convenient community services that they perceive as responsive to their needs.

During our six months of service, we have helped veterans gain and maintain employment, prevent incidents of violence, abstain from alcohol and other drugs, reduce marital discord and family breakup, obtain emergency hospitalization and inpatient treatment, and decrease anxiety, flashbacks, nightmares, insomnia, etc. We have heard almost unanimous appreciation for our program from veterans and from other helping agencies in the community.

ROBERT W. STEWART, ED.D.
LICENSED PSYCHOLOGIST
CERTIFIED BIOFEEDBACK THERAPIST

STATEMENT OF

T. P. MULLON

REGIONAL DIRECTOR, MIDWESTERN REGION

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

AT DENVER, COLORADO

OCTOBER 22, 1983

Mr. Chairman and Members of the Subcommittee:

We are pleased to have the opportunity to address the subcommittee on the provision of health care services to veterans in Region 5 and Medical District 24.

I will preface my remarks with the fact that Medical District 24 is the largest medical district in the nation covering all or parts of nine states, a total of 490,519 square miles. As such, this District faces unique health care delivery problems seldom experienced by other medical districts.

The District is also unique in that it contains medical centers that rank among the largest and most complex. Denver and Salt Lake City, and the smallest, Miles City. Two psychiatric facilities, Fort Lyon and Sheridan, and three primary and secondary care facilities, Grand Junction, Fort Harrison and Cheyenne, complete the complement of medical centers in District 24.

Of the 205 counties served by the Medical District, 98 have been designated as health manpower shortage areas for primary care and 97 counties are considered medically underserved areas.

Unlike many areas of the country that are experiencing significant population decreases, Medical District 24 with its abundant supply of energy resources such as coal, oil and natural gas, is experiencing large immigrations of people. For example, between 1970 and 1980 the general population increased 29 percent and adult males increased 49 percent. This growth is expected to continue through 1990 at an average rate of 3 percent. Veteran population in District 24 currently stands at 779,000 including 32,000 female veterans, and is expected to decline slightly to 757,000 by 1990. However, those over age 65 will account for 22 percent of that total, nearly 167,000 veterans.

The eight medical centers in the District contain a total of 2,273 authorized beds, 198 of which are nursing home care beds. Within the total of 4,523 full time employees (FTEE) are 202 physicians and 836 registered nurses. 186 house officers from two affiliated medical schools provided additional physician support to the Denver and Salt Lake City Medical Centers.

As of September 30, 1983, 37,038 veterans were treated as inpatients and 398,316 outpatient visits were accomplished. Patient treated were 12% and outpatient visits were 9% over plan. The average occupancy rate for the hospitals in the District was 82%.

Over the past 4 years, 2,802 veterans were examined under the Agent Orange Screening Program and 135 were examined for the effects of ionizing radiation.

The combined District Budget for FY 83 was in excess of $139,000,000. 2.6 million dollars and 94 employees are engaged in 124 funded medical research activities in the District.

The 1983 Jobs Bill accomplished 31 projects at a cost of $2,800,000. The Medical District has approved 33 maintenance and repair projects for FY 84 at a cost of $2,600,000.

Significant clinical improvement projects currently underway include: a 21 million dollar renovation of Building 1 at Cheyenne, 46 million dollar clinical support wing at Denver, a 60 bed nursing home bed unit at Denver, an outpatient addition at Sheridan, a clinical addition at Grand Junction and a patient privacy project at Grand Junction. Future projects include: 60 bed nursing homes at Fort Harrison, Salt Lake City and Sheridan, a clinical addition at Fort Harrison and a mental health building and a 30 bed spinal cord injury center at Salt Lake City.

The Medical District's efforts under the MEDIPP process have been noteworthy. Some of the initiatives currently being considered to meet the needs of the aging veteran include: a plan to increase VA nursing home care beds to 502 by 1990, to increase the use of contract nursing home care beds by 56% by 1990, to increase the state nursing home census by 93%, and establish a 60 bed domiciliary at Salt Lake City.

The geographic size and topography of the Medical District presents serious obstacles to the veteran residing in isolated rural areas who wishes to access the VA system. To meet this need, the District has devised some innovative approaches beyond traditional ones that appear to be cost effective. The first of these is the tertiary medical center outreach program that provides for teams of specialists to travel to the smaller non-affiliated medical centers to conduct specialty clinics in otolaryngology (ENT), neurology, neurosurgery, ophthalmology, optometry, orthopedics, urology, vascular surgery and others. The purpose of these clinics is to provide specialized out-patient follow-up care for patients who have been treated by a tertiary medical center and transferred or discharged back to their home VAMC. These clinics also screen non-emergent patients who may need further specialized care at a tertiary medical center and they provide for patient and physician consultation by specialists of the highest caliber.

A second outreach program is the medical center that provides primary service at a location more convenient to the patient. The purpose of these programs are to provide post-hospitalization follow-up care, home health care for housebound veterans and health and nutrition education. Current sites for these clinics are, Richfield and Roosevelt, Utah; Torrington and Laramie, Wyoming; and Fort Collins, Fort Morgan, Colorado Springs and Pueblo, Colorado.

Other programs of this type are in operation in other parts of Region 5 and are being analyzed to determine the efficiency of continuing or expanding this concept.

That concludes my statement, Mr. Chairman, I will be pleased to answer any questions you or members of the committee may have.

PREPARED
STATEMENT OF ROBERT E. LINDSEY, JR.
MEDICAL DISTRICT DIRECTOR
MEDICAL DISTRICT NO 24
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
OCTOBER 22, 1983

Mr. Chairman, it is a pleasure to testify before the Committee today on alternatives to providing health care to veterans located in areas geographically isolated from VA medical facilities.

I. BACKGROUND

Medical District No 24 is seriously attempting to improve accessibility to VA health care for those veterans who reside within the vast geographic boundaries of this Medical District.

The philosophy of this Medical District is that any veteran beneficiary who applies for care has the full range of medical capacity available within the Medical District. This Medical District is comprised of eight VA Medical Centers consisting of:

Tertiary Referral Medical Centers
    Salt Lake City, Utah
    Denver, Colorado

Primary and Secondary Medical Centers
    Grand Junction, Colorado
    Cheyenne, Wyoming
    Fort Harrison, Montana
    Miles City, Montana

Psychiatric Medical Centers
    Fort Lyon, Colorado
    Sheridan, Wyoming

Additionally, the Medical District has adopted the approach that all the available health care resources not be expended only for those eligible beneficiaries who choose to live in near proximity to a VA Medical Center. Some of the more serious and numerous complaints from veterans pertain to their belief that they have been arbitrarily excluded from the receipt of health benefits to which they are entitled because they choose to live in rural America or in a location distant from a VA Medical Center.

The Medical District Initiated Planning Process (MEDIPP) has been of tremendous benefit in fostering the identification of need and implementation strategies of providing access to VA health care for veterans who reside in rural areas.

The trend in innovative health care delivery systems in Medical District 24 is toward providing care needed at a location most convenient to the patient. This must be accomplished within the constraints of resources available, cost effectiveness, quality assurance, and veteran eligibility requirements.

The original motivation was to achieve realistic reductions in the beneficiary travel expense related to long-distance transportation of patients for relatively minor, but necessary, treatment episodes. The more recent important motivating factors have been patient convenience and the need to provide equitable accessibility to the VA Health Care System. It has been observed, for almost three years, to be less expensive to transport treatment teams to a distant clinic location, which has been scheduled in advance, than it is to transport several patients to the central medical facility. While it may be somewhat inconvenient for the physician, nurse, etc., the patient finds it considerably more convenient in relation to employment, personal schedules, and time away from home.

Some of the most innovative and cost effective aspects of medical outreach have come from the various modes of outreach devised by the treatment specialists themselves. A variety of mechanisms have been utilized from charter airlines, commercial airlines, motor vehicles, and a combination of team and patient travel to a neutral location, to the hiring of physician extenders and local physicians in establishing rural clinics.

It is anticipated that some of these projects may demonstrate the need for new or adoptable technologies not presently utilized in hospital care. With the introduction of great distances between the treatment teams and home base, needs for communication, scheduling, lightweight sophisticated equipment, less complex procedures and a need for increased patient confidence and satisfaction become critical factors. The lack of immediate access to the full range of hospital-based diagnostic capabilities and treatment modalities places the team in a new environment which tends to produce more treatment oriented methods and procedures. The overall result may possibly be a more discriminating attitude on the part of team members toward increasingly efficient treatment programs for each patient. Elimination of unnecessary but convenient tests and procedures may likely be one significant benefit of these innovative delivery systems.

The geographical size and topography of the Medical District presents serious obstacles to the veteran residing in isolated rural areas who wishes to access the System. The same factors seriously drain medical centers' budgets when beneficiary travel must be paid to transport patients distances up to 480 miles for medical care.

The following reflects critical needs for innovation faced by Medical District 24, the goals and objectives, alternative approaches devised and implemented, affiliation support of these ventures, and an analysis of the impact of these innovations and salient related issues for consideration.

II. STATEMENT OF NEED

Geographically, Medical District 24 is much larger than any other district, as well as being larger than two of the six Department of Medicine and Surgery Regions, within the current VA structure. Medical District 24 covers 14 percent of the Continental U.S. land area; however, only 2.5 percent of the total Continental U.S. population is within the District boundaries.

The medical centers within Medical District 24 are separated by great distances from each other due to the geographical expanse of the District. The District is also sparsely populated, with great distances between populated areas of any size. The relatively long distances for travel within the Primary Service Areas, as well as between VAMCs, translates into unusually large beneficiary travel expenses within Medical District 24. This large expanse has been of major concern throughout the District and has been a prime motivator to develop innovative approaches to reduce patient travel expenses and to use the travel money saved to improve patient care.

Several of our medical centers are located in remote, small communities seriously lacking in educational offerings and medical specialists, either in-house or by fee basis consultation. This limits both the number of prospective employees and professional services available through these medical centers. Innovative approaches must be utilized to meet the patient care needs of the veteran patients residing within these areas.

Six of the eight medical centers within the District are non-affiliated, remotely located, and isolated by great distances from metropolitan clinical and educational bases. It is extremely difficult for these medical centers to recruit and retain competent staff at the more highly trained levels. Innovative approaches to obtain these services from other medical centers through various sharing arrangements are essential to patient care.

Veterans residing in these widely dispersed and isolated communities are afforded little opportunity to receive VA medical care because of nearly overwhelming obstacles to accessing the system. Within Medical District 24, only a limited number of veterans in the rural areas persist in their attempts to overcome the obstacles and travel to one of the medical centers to take advantage of the benefits for medical care to which they are entitled. The failure of these veterans' attempts to access the system is demonstrated by statistics which show that the majority of patients who receive hospital inpatient treatment live within a 100 mile radius of the medical centers.

Because of the above, Medical District 24 has devised innovative approaches, beyond the traditional ones, to meet patient care needs within the constraints of cost effectiveness, quality assurance and veteran eligibility requirements.

III. MEDICAL DISTRICT GOALS AND OBJECTIVES

Medical District 24 major goals and objectives in devising and implementing innovative approaches in the delivery of health care are as follows:

- To continually explore cost effective, innovative means and methods to bridge the distance gaps and to reduce beneficiary travel costs in meeting patient care needs at an appropriate level of care.

- To bring specialized health services to a more convenient location for the veterans who increasingly find it more difficult, due to personal commitments and age, to travel great distances for the medical care.
- To demonstrate that clinical skills and educational opportunities can be effectively shared amongst District facilities.
- To provide tertiary care support to other medical centers to expand the level of patient services they offer.

IV. ALTERNATIVE APPROACHES

The following reflects a variety of Innovative Health Care Delivery System approaches utilized in Medical District 24.

Tertiary Outreach Clinics are held at non-affiliated medical centers. Only "surgical problem" and "medical problem" patients requiring specialist skills are to be scheduled for these clinics. These individuals are patients of the nearest medical center to their home which is responsible for their medical care, diagnostic exams (either accomplished in-house or through fee basis) and beneficiary travel to and from these clinics. The clinics are conducted by specialty teams from the tertiary medical centers sent out on a scheduled basis via chartered plane, commercial airlines, and vehicles to conduct these clinics and to facilitate the care of veteran patients by the most cost effective means possible. The chartered aircraft which transport specialists to clinic sites also carry patients, on a space available basis, between the tertiary medical center and clinic sites.

Tertiary Outreach Clinics have been established for the purpose of:

- Providing specialized outpatient follow-up care for patients who have been treated by a tertiary medical center and transferred or discharged back to their home VAMC.
- Screening non-emergent patients who may need further specialized care at a tertiary medical center.
- Providing a patient and physician consultation.
- Doing minor diagnostic studies.

The Salt Lake City VAMC conducts Tertiary Outreach Clinics at the Fort Harrison VAMC (Montana) in Neurosurgery, Ophthalmology, Optometry, Orthopedics, Urology and Vascular Surgery. Miles City VAMC (Montana) patients are seen at Fort Harrison, thus reducing the cost of transportation for specialized care. These clinics were established during May-September 1980.

The Salt Lake City VAMC also conducts Tertiary Outreach Clinics at the Grand Junction VAMC (Colorado) in Otolaryngology, Neurology, Neurosurgery, Ophthalmology, Optometry, Physiatry and Urology. Some of these clinics started in the early 1970's at the request of the Grand Junction VAMC while three began just recently.

Tertiary Outreach Support Services are provided to non-affiliated medical centers in expanding the level of patient services offered at these facilities.

There is a chartered flight weekly between Denver and Fort Lyon (Colorado) to send professionals from the Denver VAMC to provide needed clinical support care to the Ft. Lyon Patients. Two Psychiatrists and one Podiatrist spend one day per week at Ft. Lyon and Orthotics provides service to Ft. Lyon two days a month. Also, other Denver VAMC staff members travel intermittently at the request of Ft. Lyon to provide needed services and assistance. The remote, isolated location of Ft. Lyon makes it very difficult to recruit and retain needed professional expertise. It is also noted that the need for specialized care at a long-term psychiatric facility, such as Fort Lyon, is more limited in comparison to that required in an acute General Medicine and Surgery facility, and even if it were possible to recruit the highly specialized medical personnel, it is more cost effective to obtain these services in the present manner.

The Denver VAMC sends a representative from its Prosthetics Service one day a month to conduct a Prosthetics Clinic at the Grand Junction VAMC. Denver's Prosthetic Service measures patients for prosthesis, fabricates and repairs prosthesis, consults on difficult/special cases, etc., in assisting Grand Junction meet a significant portion of the prosthesis needs of their patients. The Denver VAMC is the Clinic of Jurisdiction for the state of Colorado for fee basis, including prosthetics.

MediVAn Outreach Clinics were established primarily to provide follow-up primary care to discharged veterans who reside considerable distances from the VAMC.

Over two years ago, the Denver VAMC established a Mobile Internal Medicine Clinic (MediVAn) to provide access to primary care for veterans living more than fifty miles from the medical center. A 30 foot van was purchased and equipped as an internist's office. The van consisted of the following three functional areas: the front area with driver and passenger seats and a small waiting area; the examining room; and the rear area containing a small laboratory, toilet, sink, and storage space for prepackaged drugs.

The MediVAn was on the road three days a week seeing patients in Greeley, Colorado (53 miles north), Ft. Morgan, Colorado (79 miles northeast), and Ft. Collins, Colorado (63 miles north). The MediVAn parked at veterans' service organization facilities which provided electrical hook-ups for the MediVAn and a check-in and waiting area for the patients. Sites were selected based on distance from Denver and number of veterans in the area. This same MediVAn team started the Colorado Springs Clinic from the van and have continued the same services within the free-standing clinic after a building was located.

The MediVAn was staffed by the following three permanent employees: a physician, a health technician, and a coordinator. Physician responsibility was shared among the full-time ambulatory care staff at the Denver VAMC, all of whom are board-certified internists and members of the University of Colorado School of Medicine faculty. Each internist went to the same MediVAn site every other week to establish his or her patient population and to maintain continuity of care. The MediVAn was driven by the health technician, who was responsible for overall maintenance of the van, check-in and check-out of patients, drawing blood, giving injections, and serving as liaison with local service organizations. The MediVAn coordinator acted as the office manager at the Denver VAMC and was responsible for appointments, obtaining charts from the file room, purchasing and supplies, serving as liaison with the clinical laboratory and pharmacy, and maintaining records for research and cost analysis.

The MediVAn was established on an appointment-only basis. Appointment cards were maintained by the coordinator, who received referrals from primary care providers at the Denver VAMC, ward discharges from the Denver VAMC, veterans service officers at the MediVAn sites, and patients who called in after hearing about the MediVAn through friends or the media. Since medical records were maintained at the Denver VAMC and transported with the MediVAn for appointments, walk-in patients were seen without the benefit of records and were therefore discouraged. However, this policy was enforced at the discretion of the individual physician and there was variability in the number of walk-in patients seen at the various sites. Emergencies were referred to the nearest local emergency facility. When a patient became ill between MediVAn visits he contacted his physician in Denver, who determined whether the patient could wait until the next MediVAn visit, should be seen sooner in Denver, or should be referred to the nearest hospital emergently.

Recently, due to the evolutionary learning experience and analysis of demographic data, the MediVAn model is being discontinued in favor of permanent space being provided by Service Organizations. Greely, Colorado has been eliminated as a site. Ft. Morgan, Colorado, Ft. Collins, Colorado and Colorado Springs, Colorado have been continued, with essentially the same schedule and staff as before.

Free-Standing Clinics are established in major population centers where a large number of veterans reside, and are justified by a requirement for significant primary care services.

The Denver VAMC opened a free-standing Outpatient Clinic in Colorado Springs, Colorado (67 miles south) in FY 81. It currently provides psychiatric and dental services five days a week and medical services one day a week. The medical services are provided by the MediVAn staff who travel from Denver and operate out of the Clinic in place of the MediVAn service they previously provided. After hour emergency psychiatric coverage is provided by a sharing agreement with the Pikes Peak Mental Health Association located in the same building. Denver indicates the potential workload for this clinic is much greater than earlier projected. The clinic is expected to reduce high costs previously experienced by the Denver VAMC for fee dental work and beneficiary travel.

Billings, Montana (150 miles west of the Miles City VAMC, Montana - 135 miles Northwest from the Sheridan VAMC, Wyoming) is under consideration as a potential site for a free-standing outpatient clinic.

Rural Health Outreach Clinics are being established for the purpose of:

- Providing post-hospitalization follow-up care.
- Providing home health care for housebound veterans.
- Triaging prior to specialty clinic visits.

- Providing acute care/emergency triage.
- Health and nutrition education.

It is anticipated the Rural Health Outreach Clinic Program will result in the following:

- Savings in beneficiary travel.
- Shorter hospital stays.
- Decrease in unnecessary hospital readmission rates.
- Identification of illness states in early stages, allowing more effective medical intervention, and more favorable patient outcome.
- Decrease in the number of unnecessary outpatient clinic visits.
- Increased patient satisfaction with both the medical care they receive and with the Veterans Administration and its attempts to provide veteran benefis.
- Increased equity in services provided veteran beneficiaries in rural areas.

Rural Health Outreach Clinics provide primary health care, referral, and post hospital follow-up services to veterans residing in isolated rural areas. The geographic size and topography of Medical District 24 presents unique problems to these veterans, many of whom reside hundreds of miles from VA Medical Center-based services.

The problem presented by the long distances are compounded by the lack of public transportation services: a few locations are served by rail transportation; some of the cities have direct air service; other communities on the major north-south and east-west highways must rely upon bus transportation; those communities which are located remote from these routes have to depend solely upon private vehicles for transportation to the nearest bus terminal. At its best, bus transportation is minimally acceptable due to infrequent and inconvenient schedules and the extended time required for bus travel. With very few exceptions, it is not possible for a veteran to travel from his home to the medical center for a clinic appointment or evaluation to determine his need for hospitalization, and return to his home on the same day, either by bus or by private car. The severe weather conditions which are experienced throughout the Medical District make travel difficult during the months between early October and late March. At times, during those months, roads are impassable up to 2-3 days at a time because of heavy snow and drifting, especially in the mountain passes.

Other factors which characterize Medical District 24 rural outreach locations include large areas which have been designated by the Department of Health and Human Services as being Medically Underserved Areas, or Health Manpower Shortage Areas. Many areas have been designated as both medically underserved and as having health manpower shortages. Health care delivery in these areas are further impacted by rapid population growth due to energy-related development.

The Salt Lake City VAMC designed the Rural Health Outreach Clinic Program in two phases; Phase I consists of establishment of "model"/demonstration Clinics, Phase II includes identification of additional potential Clinic sites throughout the VAMC's Primary Service Area. Development of Phase II sites will be based upon analysis of data and experiences at the model/demonstration sites. Two model/demonstration Clinics are presently operational; Roosevelt, in Northeastern Utah, and Richfield, in South-central Utah. All sites were selected because of their central location in a geographic area of the State with large numbers of veterans, because they are trade and social centers for their area, and because obstacles to travel and access to health care are of particular concern at these locations.

The Roosevelt Clinic opened September 1982 and the Richfield Clinic opened in November 1982. Each Clinic is staffed with a full-time secretary and a full-time Physician's Assistant. Physician services and supervision of the Physician Assistant is provided by either local physicians hired as part-time VAMC staff physicians, or by physicians based at the Salt Lake City VAMC. Supervision by VAMC-based physicians is provided both at the Clinic site by a traveling physician (part-time) and by immediate telephone consultation with staff physicians in the specialties and sub-specialties. The secretary is supervised by Medical Administration Service at the Medical Center.

Outreach Health Clinic physicians and physician assistants work closely with the VAMC medical staff to assure continuity of care for patients discharged from the hospital to be followed in the rural clinics. This allows closer monitoring of changes in the patient's medical condition and earlier referral to appropriate specialty clinics to avoid emergencies and the need for re-hospitalization. Also, the admission process for patients who require hospitalization is facilitated, and VAMC resources can be more appropriately utilized and scheduled, when triage is accomplished prior to the veteran's arrival at the Medical Center. The triage and workup performed in the Outreach Clinics assure that the patient enters VAMC treatment at the appropriate level of intensity of services and screens out those veterans who do not require Medical Center services, prior to the expenditure of travel funds. Decision points occur much earlier in the patient-evaluation process, resulting in a more efficient use of resources and a decrease in unnecessary services and beneficiary travel.

Communications and tracking of patients, between the Rural Health Outreach Clinics and the Medical Center, is accomplished through telephone and computer linkages, Medical records data and doctors' orders can be input from both Medical Center and Clinic sites, further assuring continuity of care and appropriate monitoring of critical data such as laboratory test results, drug profiles, and follow-up treatment plans and schedules.

The overwhelming acceptance of the Outreach Health Clinics by the State's veterans and by the veterans organizations and the communities themselves, is in part due to the recognition of the higher quality of care received by the veteran when his care is no longer "fragmented" between what he receives at the VAMC in Salt Lake City and private health care providers located in multiple small communities in the geographic area in which he resides. The modest size of the Rural Outreach Clinics also allows the staff to provide more personalized attention to the veteran and a more comprehensive evaluation and documentation of his medical history, and his health education than can possibly be provided in the community's overloaded health care resources or even in the fast-paced tertiary care VAMC in Salt Lake City. While it is still too early to have hard data to demonstrate, it is the observation of Clinic staffs that the patient is more compliant with his treatment plan when patient education can be reinforced through more frequent monitoring follow-up visits. Some of these visits are simply a drop-in visit to report progress to the Clinic staff who have become a part of the veteran's social support network. It is expected that this kind of close follow-up will result in decreased episodes of hospitalization and significant savings in beneficiary travel expenditures.

The Outreach Clinics are also providing excellent demographic data upon which to base projections for future health care needs. The Clinics' patient population characteristics, including presenting complaints and diagnoses demonstrate potentially significant differences from those of the urban population and may provide us with the capability to identify trends which are important to long-range planning.

Traveling Follow-up Clinics provide post-hospital outpatient follow-up care at locations more accessible to the veteran. The purpose is to keep the veteran functioning within the community and minimizing his return to the medical center. These clinics are conducted at two-week or less frequency, and are conducted in facilities at the locations visited.

The Cheyenne VAMC started holding an outreach follow-up clinic every other Friday in Torrington, Wyoming (80 miles northeast) in March 1982 in a veteran service organization facility. A similar clinic in Laramie, Wyoming (50 miles west) was opened in September 1983. All clinic patients are pre-scheduled; walk-in patients are referred to the Cheyenne VAMC.

The Cheyenne VAMC is also considering Casper, Wyoming (180 miles northwest) and Sidney, Nebraska (87 miles east) as possible Outreach Follow-up Clinic sites.

The Ft. Lyon VAMC started holding outreach follow-up clinics in Pueblo, Colorado (90 miles West of Ft. Lyon, 100 miles South of Denver) on January 31, 1983. A Medical Clinic (1½ days) is conducted every other week at the DAV Center. Mental health services as well as psychological and social work counselling services are provided (1½ days) on a weekly basis through the DAV Outreach Program located at the Job Service Center. All clinic patients are pre-scheduled, walk-ins are discouraged and only seen if schedule allows. The traveling team includes the coordinator and representatives from Medicine or Psychiatry Service, Nursing Service, Social Work Service, Psychology Service and Medical Administration Service.

Residential Care services are provided by the Cheyenne, Denver, Ft. Lyon, Salt Lake City, and Sheridan VAMCs. These VAMCs are dispersed activity centers due to the considerable distances between the VAMCs and towns they provide residential care services for.

V. AFFILIATION SUPPORT

The Surgical Specialty Outreach Clinics conducted by the Salt Lake City VAMC Surgical Service are generally attended by residents on a rotational basis. Attending and conducting these clinics are considered to be part of their training and educational activities while on rotational assignment at the Salt Lake City VAMC. The Salt Lake City VAMC surgical staff feels that some of the very best teaching and operative cases come from these and other areas outside the Salt Lake City VAMC Primary Service Area. These physicians fly by charter or commercial flights to hold these clinics 287 and 477 miles away from home base. This is a unique opportunity for residents.

VI. ANALYSIS OF IMPACT

The innovative delivery systems presently utilized are, for the most part, still in the adolescent stage of development and implementation. The comments below reflect the District's experience to date.

Savings - Medical centers have experienced a savings in beneficiary air travel, lodger and patient escort expenses as a result of doing more initial patient evaluation and follow-up by specialists at the various surgical and medical outreach clinics.

Since one of the major objectives in establishing these innovative delivery systems was to reduce beneficiary travel expenses, a part of the design of these systems has been to return patients back to their "home" VAMC for follow-up, within the limits of that facility's capabilities. Along with this move was the responsibility of the "home" VAMC to provide any further diagnostic tests, medications, beneficiary travel to outreach specialty clinics, and other resources required by their patients. This resulted in some shifting of expenses and workload from tertiary medical centers to the "home" facility.

There are many variables involved which make it difficult to accurately identify all of the savings which occur. Such variables include:

- Differences amongst physicians in ordering diagnostic tests and prescribing treatment.
- Differences in the number of patients being seen in the newly established outreach delivery systems versus those that would have been sent (usually by air) to a tertiary or other medical center if we did not have these outreach systems.
- Difference in operational policies between medical centers.

Relatives usually serve as attendants to patients coming to these outreach clinics. Before establishing these outreach clinics, Medical District 24 had to hire attendants to accompany patients to a tertiary medical center.

It should be noted that a number of Outreach efforts have been made to improve medical accessability for the veteran patient within the constraints of available resources and for which an appreciable savings has not been identified.

Quality of Patient Care - Participating medical centers feel that the quality of patient care has been improved through the outreach programs. Specialized outpatient care is now available to patients in non-affiliated medical centers. The traveling specialists also see inpatients in clinics, hold patient care rounds, and conduct educational seminars for medical center staff. It has been noted that the traveling specialty VA consultants exhibit a much stronger commitment to medical care to the veteran than do non-VA consultants in the community. This commitment translates into a higher quality of care. Patients requiring specialty consultation are seen much earlier than previously, when the specialty clinics were held only at the tertiary site, resulting in shorter waiting lists and earlier medical intervention and rehabilitation. The degree of cooperation and communication between physicians in the tertiary and non-affiliated medical centers has grown significantly, resulting in more frequent and more immediate consultation requests and responses, and subsequently in increased quality of care. Participating medical centers feel the improved level in quality of patient care being realized on a district basis is a definite plus for both continuing and expanding the usage of this innovative health care delivery system.

Teaching Program - The screening of patients at these outreach surgical clinics to eliminate expensive and unnecessary patient travel to the Salt Lake City tertiary VAMC has resulted in more appropriate patient cases through more sensible referrals, many of which represent some of the very best inpatient teaching and operative cases for the surgical service. The affiliated resident teaching program has been expanded to include outlying specialty clinical experience which also has broadened the residents' exposure and association with other VA staff and local non-VA physicians in the treatment of patients. These clinics not only provide additional educational experience for the residents, but also for the professional staff at the non-affiliated medical centers. It has stretched the training dollars for these VAMCs through patient consultation and seminars made available to them. The chartered planes are large enough that seats are available for additional staff to be transported for educational purposes at no extra cost. VAMCs report that physicians at both affiliated and non-affiliated medical centers better understand what each other has to deal with and have a better understanding of the total picture involved between the two types of medical centers in meeting patient care needs. Medical centers feel that the teaching and education programs have definitely been enhanced through these outreach specialty clinics.

Working Relationships - Medical centers involved feel that these innovative outreach systems have enhanced esprit de corps and cooperation between MD 24 VAMCs. The benefits being realized seem to be pulling the system of VAMCs together in a "team approach" in the treatment of veteran patients.

Facilities - These innovative approaches seem to be relieving some of the congestion and burden in the outpatient departments at the tertiary medical centers as well as resulting in better utilization of excellent facilities available at the unaffiliated medical centers.

Patient Records - The screening of patients for referral to the tertiary care facilities for further care has reduced the number of patient folders transferred and the possibility for their loss. VAMCs reported they have had to "clean up" their act internally, in records retrieval.

VII. ISSUES FOR CONSIDERATION

Careful planning and a thorough review of potential issues are critical to the degree of success that will be achieved in meeting patient care needs most effectively and economically within resources available. From MD 24's experience thus far, the following issues or points are most salient when considering the implementation of innovative outreach health care delivery systems.

- Demographic and projected workload - A determination must be made as to the present and projected future patient care needs of the patient population served. The type, amount and frequency of patient care needs by specialty, beyond the maximum capability of a VAMC, must be identified before plans can be developed to most efficiently acquire the needed augmentation of specialty skills and assistance.

- Policy statements - Appropriate District policies should be developed to establish mutual understanding as to the operational aspects of outreach medical/surgical ventures. Conflicts in established policy statements at the individual medical centers must be resolved.

- Physicians workload and commitments already established at their assigned VAMC and University Medical Center.

- Administration's support and commitment to such outreach ventures.

- Type of facilities and diagnostic equipment available at or for clinic sites.

- Type of services to be provided at the clinics.

- Funding required, and source from which funding will be derived.

- Staffing support for clinics - what is needed and where will it come from.

- Transportation to and from outreach clinics - Who pays?

  Commercial flights present problems for physicians such as the hassle and inconvenience of travel paperwork, airline schedules, travel funds; motel accommodations; and transporting diagnostic equipment.

  Chartered flights permit physicians to fly to clinic sites, hold clinics and return the same day. However, some physicians feel the smaller charter planes are too risky, and refuse to fly in them. Most prefer the chartered jets which require the presence of a co-pilot and reduces unproductive time in the air.

- Patient Education - It is important to explain to the patients any changes in beneficiary travel or in location of clinics, to alleviate apprehension and to minimize any detriment to the physician-patient relationship.

VIII. CONCLUSION

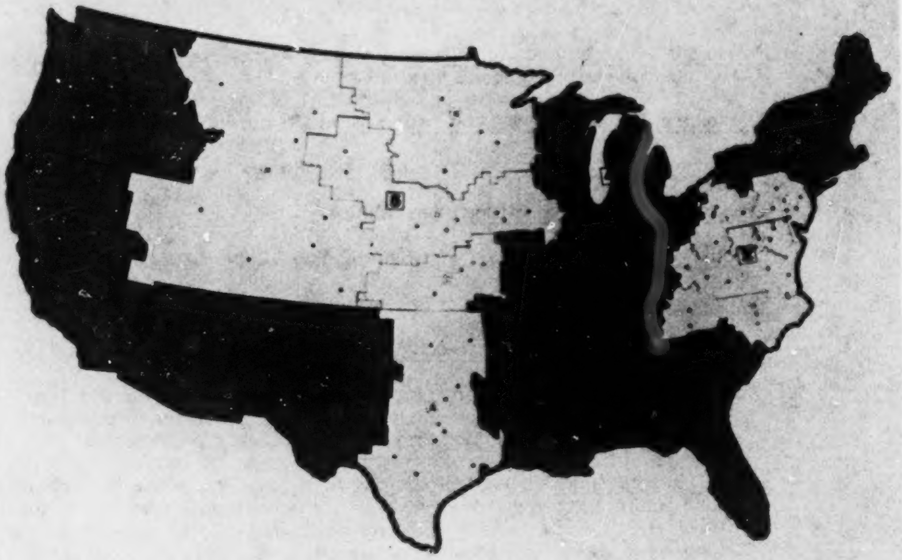
Each medical center, district and region is faced with differing resources and obstacles which must be approached based on their individual merits for effective resolution. A given set of approaches will not be appropriate or effective for all areas and, most likely, not any two areas. A health services research effort is underway to evaluate the various models of the Medical District 24 outreach efforts.

The above represents Medical District 24's needs and approaches to fulfill them. The methods used are non-traditional. The geography and population dispersion, which require use of non-traditional approaches, are in themselves unique. As a Medical District, we must constantly be aware of changes and modifications needed in our operations and approaches in the MD 24 "team effort" to successfully meet the veteran needs at the most appropriate level and within the constraints of resources available, cost effectiveness and veteran eligibility requirements.

The Medical District 24 effort to improve access to care is ongoing and planning is continuous. Future planning efforts will be incorporated into the next MEDIPP cycle.

Veterans Administration

Department of Medicine and Surgery Medical Districts and Regions



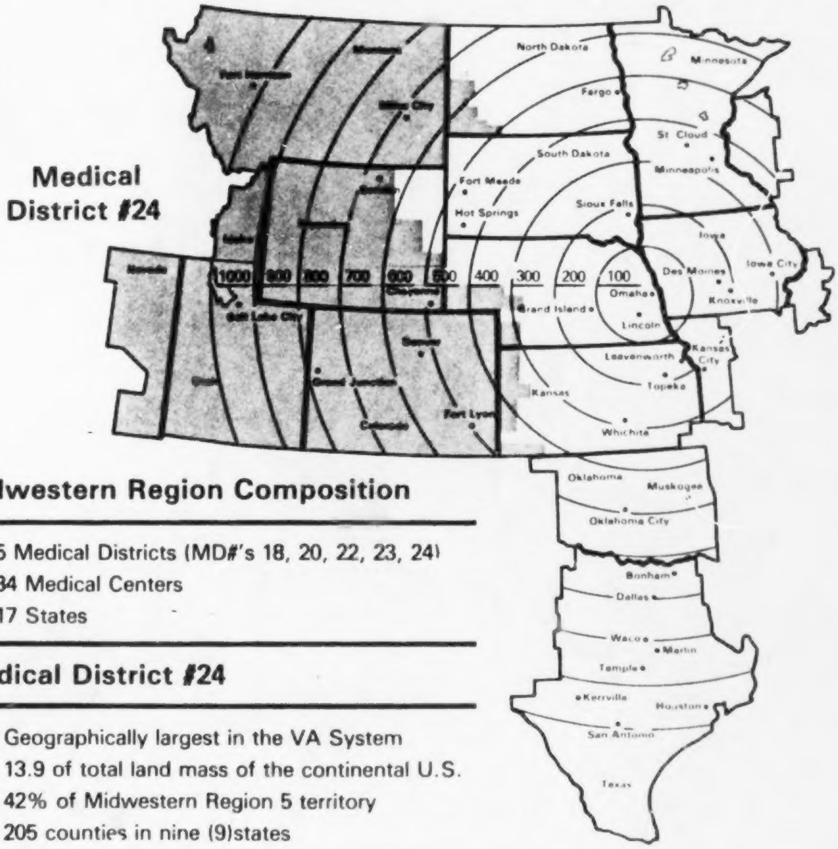
Department of Medicine and Surgery – Composition

- 6 Regions
- 28 Medical Districts
- 172 Medical Centers

Map Legend:

1 Northeast Region
2 Mid-Atlantic Region
3 Southeastern Region
4 Great Lakes Region
5 Mid-Western Region
6 Western Region

Midwestern Region 5


Medical District #24
North Dakota
Fargo
Minnesota
St Cloud
Minneapolis
South Dakota
Fort Meade
Hot Springs
Sioux Falls
Iowa
Des Moines
Iowa City
Knoxville
Montana
Miles City
Cheyenne
Salt Lake City
Denver
Grand Junction
Fort Lyon
Colorado
1000
900
800
700
600
500
400
300
200
100
Omaha
Grand Island
Lincoln
Leavenworth
Kansas City
Topeka
Kansas
Wichita
Oklahoma
Muskogee
Oklahoma City
Bonham
Dallas
Waco
Marlin
Temple
Kerrville
Houston
San Antonio
Texas

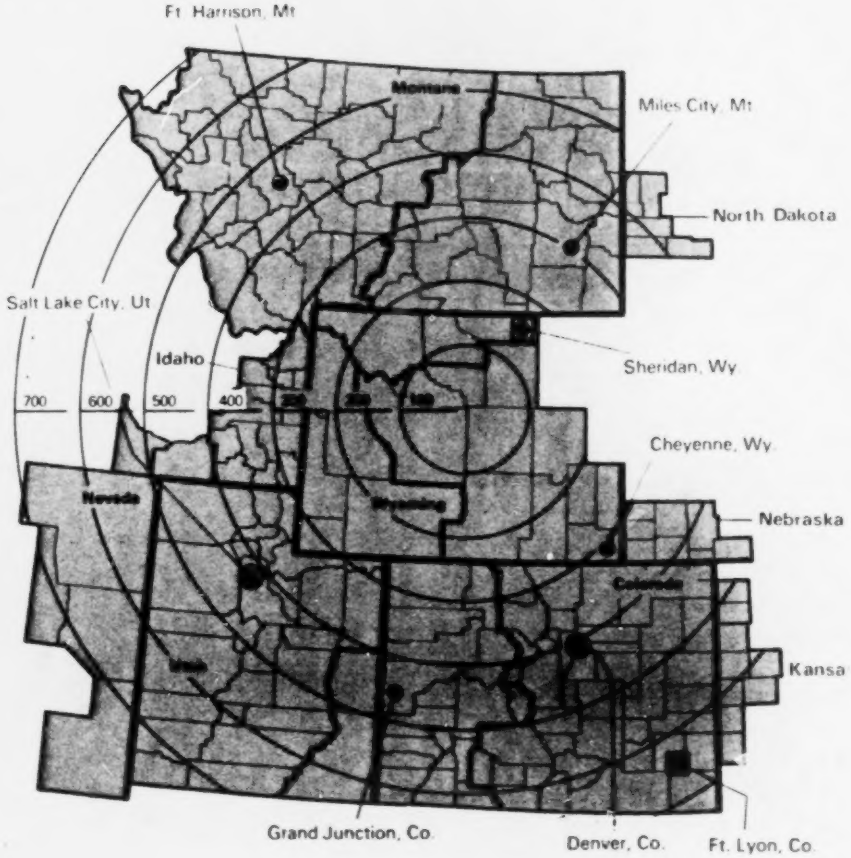
Midwestern Region Composition

- 5 Medical Districts (MD#'s 18, 20, 22, 23, 24)
- 34 Medical Centers
- 17 States

Medical District #24

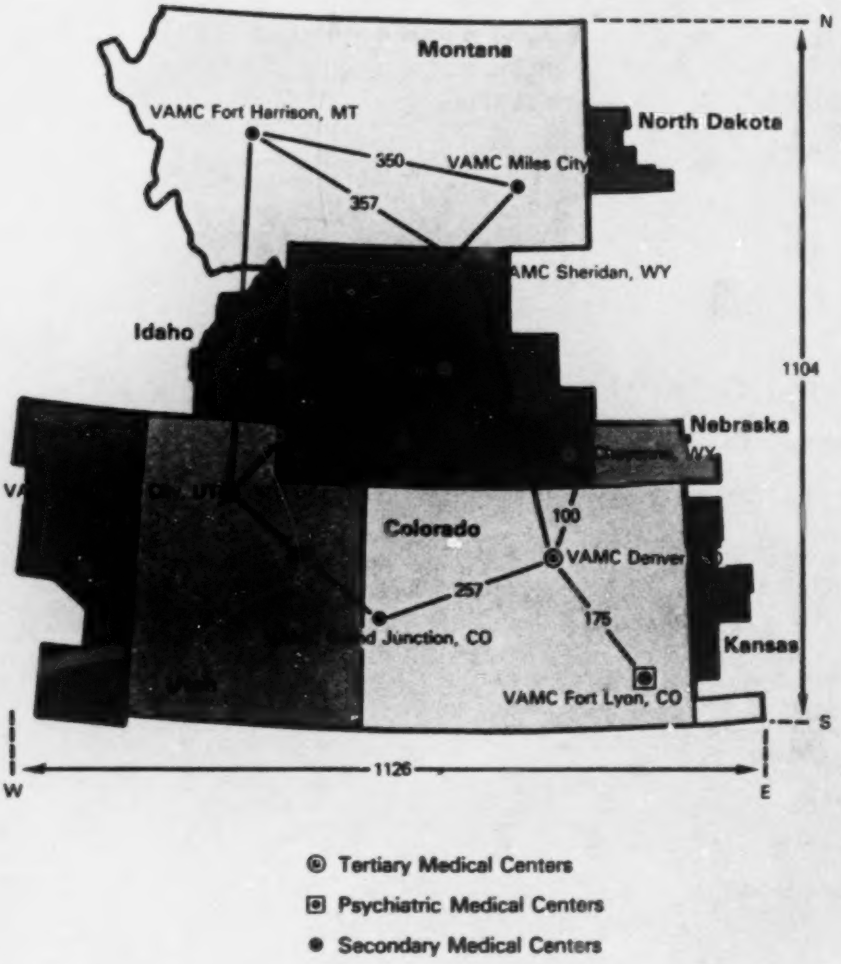
- Geographically largest in the VA System
- 13.9 of total land mass of the continental U.S.
- 42% of Midwestern Region 5 territory
- 205 counties in nine (9)states
- Only 2.5% of total continental U.S. population

Medical District 24


Ft. Harrison, Mt
Montana
Miles City, Mt
North Dakota
Salt Lake City, Ut
Idaho
Sheridan, Wy
700
600
500
400
300
200
100
Cheyenne, Wy
Nebraska
Nevada
Wyoming
Colorado
Utah
Kansa
Grand Junction, Co
Denver, Co
Ft. Lyon, Co

⦿ Tertiary Medical Centers
[•] Psychiatric Medical Centers
● Secondary Medical Centers

Medical District #24 Distances Between VAMC's


Montana
North Dakota
VAMC Fort Harrison, MT
350
VAMC Miles City
357
AMC Sheridan, WY
Idaho
N
1104
Nebraska
WY
Colorado
100
VAMC Denver
257
d Junction, CO
175
Kansas
VAMC Fort Lyon, CO
S
W
1126
E
◉ Tertiary Medical Centers
▣ Psychiatric Medical Centers
● Secondary Medical Centers

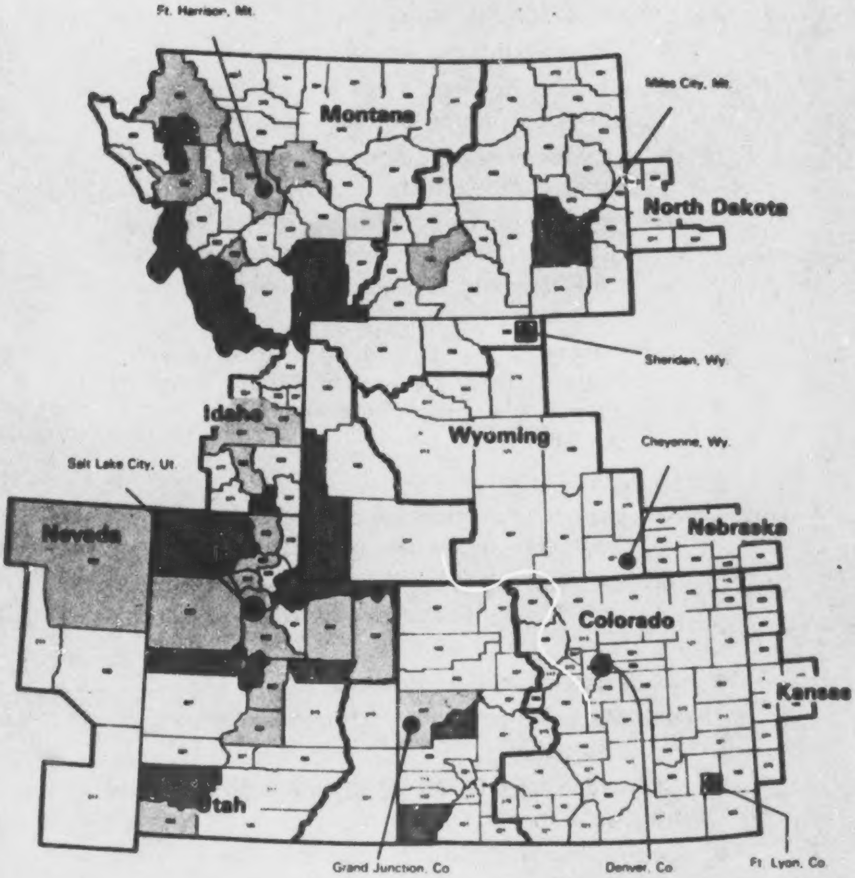
Obstacles to Providing Equal Access to VA Health Care Medical District #24

- Geographic size of medical district
- Topography of primary service areas (PSA)
- Dispersion of population
- Harsh climatic conditions

Obstacles to Veterans' Accessing Needed Health Care

- Long distances between home and VAMC's
- Transportation Problems
    - Limited public transportation
    - Distance between home and community where public transportation is available
    - Lack of personal automobile (many veterans, especially the elderly)
    - Difficulty in driving or riding for long periods of time required to reach VAMC's, especially for elderly and veterans who are ill and/or handicapped
    - Dangerous roads: winding, narrow canyon roads; snow and ice-covered roads; long distances between towns where help is available
- Cultural Differences
    - Lack of understanding of rural veteran's lifestyle by urban care providers
    - Inexperience in use of urban transportation and lodging facilities and driving in urban traffic
- Inadequate financial resources
    - Many self-employed, without health insurance
- Separation from family when care is given distant from veteran's home
- Lack of family to care for veteran in home during convalescence or extended illness
- Difficulty in providing care for livestock and farm during veteran's absence to seek care in VAMC's
- Lack of alternative health care systems. Unavailability of primary and/or specialty physicians near home

Medical District #24 Surgical Discharges from VAMC Salt Lake City


Ft. Harrison, Mt.
Montana
Miles City, Mt.
North Dakota
Sheridan, Wy.
Idaho
Wyoming
Cheyenne, Wy.
Salt Lake City, Ut.
Nebraska
Nevada
Colorado
Kansas
Utah
Grand Junction, Co
Denver, Co
Ft. Lyon, Co.

☐ Primary Catchment Area
■ Secondary Catchment Area

From Patient Origin Studies FY 1980.

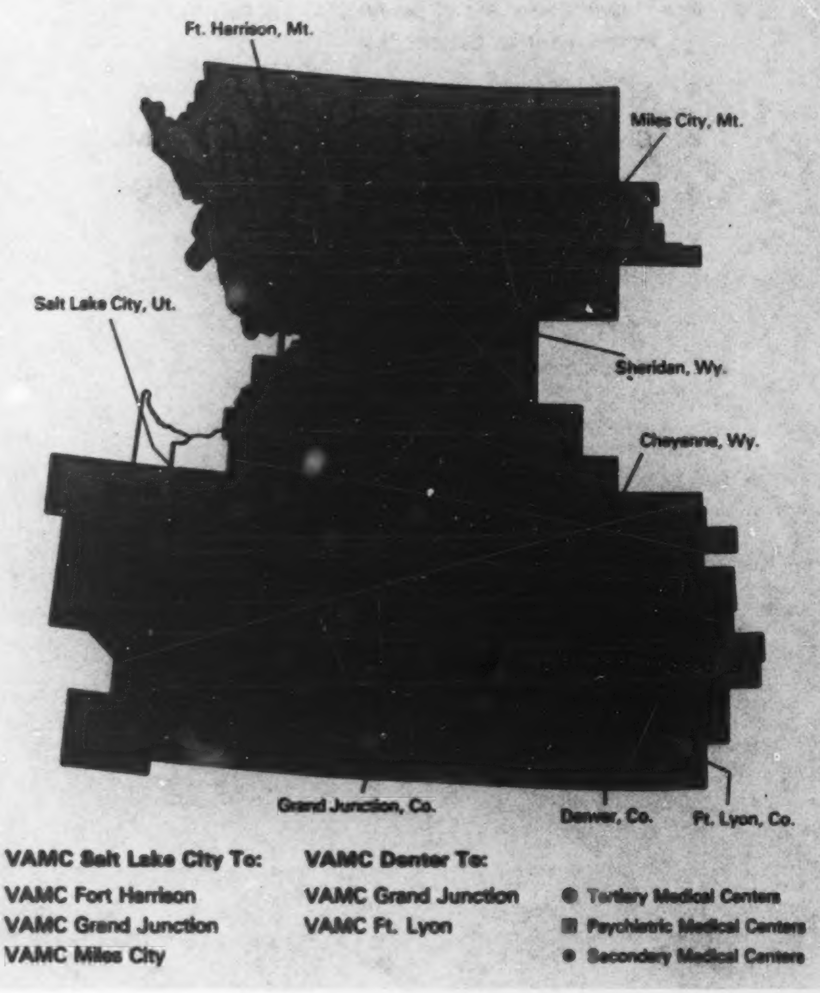
Primary Catchment Area represents 75% of surgical discharges from VAMC Salt Lake City.

Secondary Catchment Area represents the next 10% of surgical discharges.

Medical District #24
Tertiary Medical Centers
Goals and Objectives

- Provide specialized services at a location more convenient to patient
- Share Clinical skills among VAMCs
- Share educational opportunities among VAMCs
- Provide tertiary care support to other VAMCs
- Explore innovative methods to bridge the "distance gap"
- Reduce beneficiary travel costs
- Provide appropriate level of care

Tertiary Medical Center Outreach


Ft. Harrison, Mt.
Miles City, Mt.
Salt Lake City, Ut.
Sheridan, Wy.
Cheyenne, Wy.
Grand Junction, Co.
Denver, Co.
Ft. Lyon, Co.
VAMC Salt Lake City To:
VAMC Fort Harrison
VAMC Grand Junction
VAMC Miles City
VAMC Denver To:
VAMC Grand Junction
VAMC Ft. Lyon
● Tertiary Medical Centers
■ Psychiatric Medical Centers
• Secondary Medical Centers

Medical District #24 Tertiary Outreach Clinics —

- Description
  - Teams of specialists travel from VAMC Salt Lake City and VAMC Denver to hold specialty clinics at non-affiliated medical centers.

- Purpose
  - Provide specialty consultation, evaluation and followup care at locations most convenient to patients
  - Provide one-on-one education to clinical staff in host hospital

- Program Objectives
  - Reduce travel costs
  - Conserve health care resources
  - Provide equitable access to care
  - Identify illness in early stages

Tertiary Outreach Clinics

VAMC Grand Junction, Colorado

- Specialists from VAMC Salt Lake City
  - ENT
  - Neurology
  - Rehabilitation
  - Neurosurgery
  - Urology
  - Ophthalmology
  - Optometry
- Physicians from VAMC Denver
  - Orthotics

VAMC Fort Harrison, Montana

- Specialists from VAMC Salt Lake City
  - Vascular
  - Neurosurgery
  - Opthalmology
  - Optometry
  - Urology
  - Orthopedics
  - Rehabilitation

VAMC Miles City, Montana

- Patients from VAMC Miles City attend Tertiary Outreach Clinics conducted at VAMC Fort Harrison

VAMC Fort Lyon, Colorado

- Specialists from VAMC Denver
  - Psychiatry
  - Orthotics
  - Podiatry

VAMC SALT LAKE CITY
TERTIARY OUTREACH CLINIC SCHEDULE

SPECIALTY	VAMC FORT HARRISON	VAMC GRAND JUNCTION
OTOLARYNGOLOGY	--	3rd Tuesday-each month
NEUROLOGY	--	4th Friday-each month
NEUROSURGERY	2nd Tuesday-each month 4th Tuesday-even numbered months	3rd Tuesday-odd numbered months
OPHTHALMOLOGY	3rd Friday-each month	4th Friday-each month
OPTOMETRY	4th Tuesday-each month	3rd Tuesday-each month
ORTHOPEDICS	2nd Tuesday-each month 4th Tuesday-first month of each quarter	--
PHYSIATRY	3rd Friday-each month	4th Friday-each month
UROLOGY	3rd Friday-2nd month of each quarter	2nd and 4th Fridays (possible extra clinic)
VASCULAR	1st Friday-each month	--

Medical/Surgical Specialty Category of Visits to Outreach Tertiary Clinics — As a % of Total Visits by Clinic

October 1, 1980 - June 30, 1983

Specialty Clinic	*VAMC Ft. Harrison*	*VAMC Miles City*	*VAMC Grand Junction*
Otolaryngology (ENT)	2.0%[1]	6.0%[1]	24.0%
Neurology	—	—	8.0%
Neurosurgery	13.0%	12.0%	9.0%
Opthalmology	23.0%	18.0%	7.0%[2]
Optometry[3]	4.0%	0.5%	2.0%
Orthopedics	31.0%	26.0%	—
Rehabilitation Medicine[4]	0.8%	—	2.0%
Urology	11.0%	20.0%	47.0%
Vascular Surgery	16.0%	18.0%	—

1. Discontinued at Ft. Harrison/Miles City 11/81
2. Implemented at Grand Junction 9/82
3. Implemented 12/82
4. Implemented Grand Junction 12/82 and Ft. Harrison/Miles City 1/83

Number of Patients Seen in Outreach Tertiary Clinics

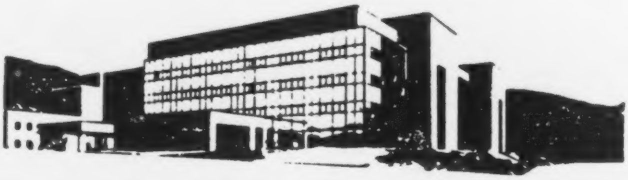
October 1, 1980 - June 30, 1983

Specialty	*VAMC Ft. Harrison*	*VAMC Miles City*	*VAMC Grand Junction*
Otolaryngology	69[1]	12[1]	567
Neurology	—	—	190
Neurosurgery	363	25	203
Opthalmology	659	39	172[2]
Optometry[3]	121	1	54
Orthopedics	884	56	—
Rehabilitation Medicine[4]	23	—	51
Urology	315	44	1112
Vascular Surgery	463	39	—
Total:	2897	216	2350

1. Discontinued at Ft. Harrison/Miles City 11/81
2. Implemented at Grand Junction 9/82
3. Implemented 12/82
4. Implemented Grand Junction 12/82 and Ft. Harrison/Miles City 1/83

Veterans
Administration

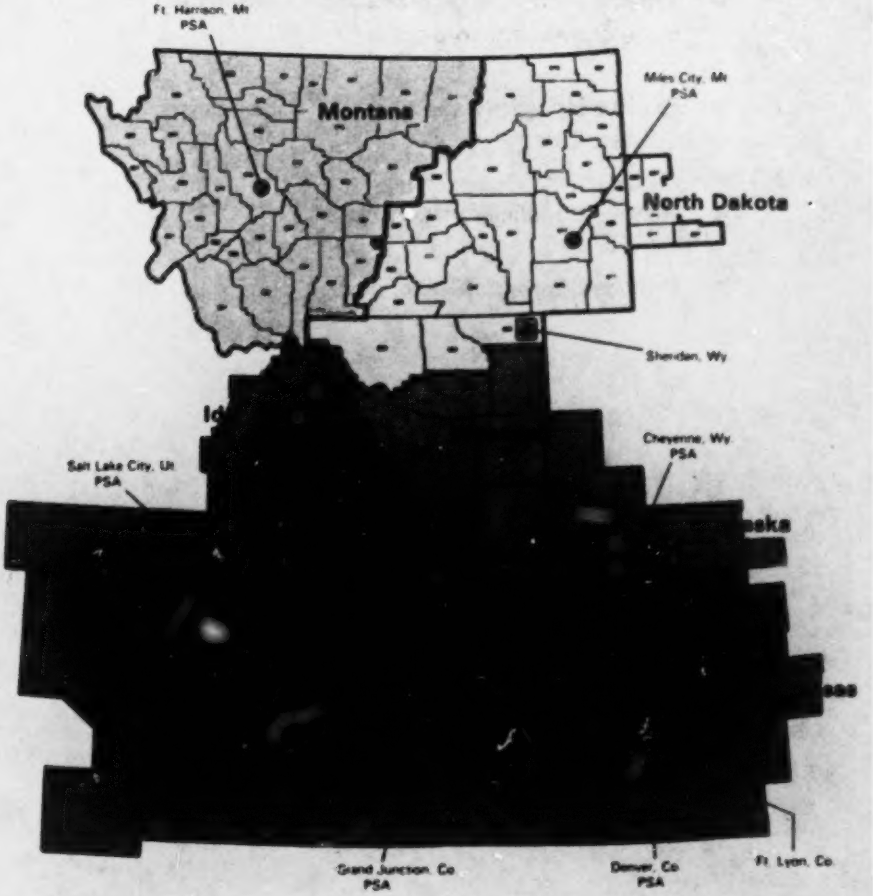
MD #24 Medical Center
Pilot Outreach Efforts



Medical District #24
Medical Center Outreach

- Provide primary specialized services at a location more convenient to patient
- Explore innovative methods to bridge the "distance gap"
- Reduce beneficiary travel costs
- Provide appropriate level of care

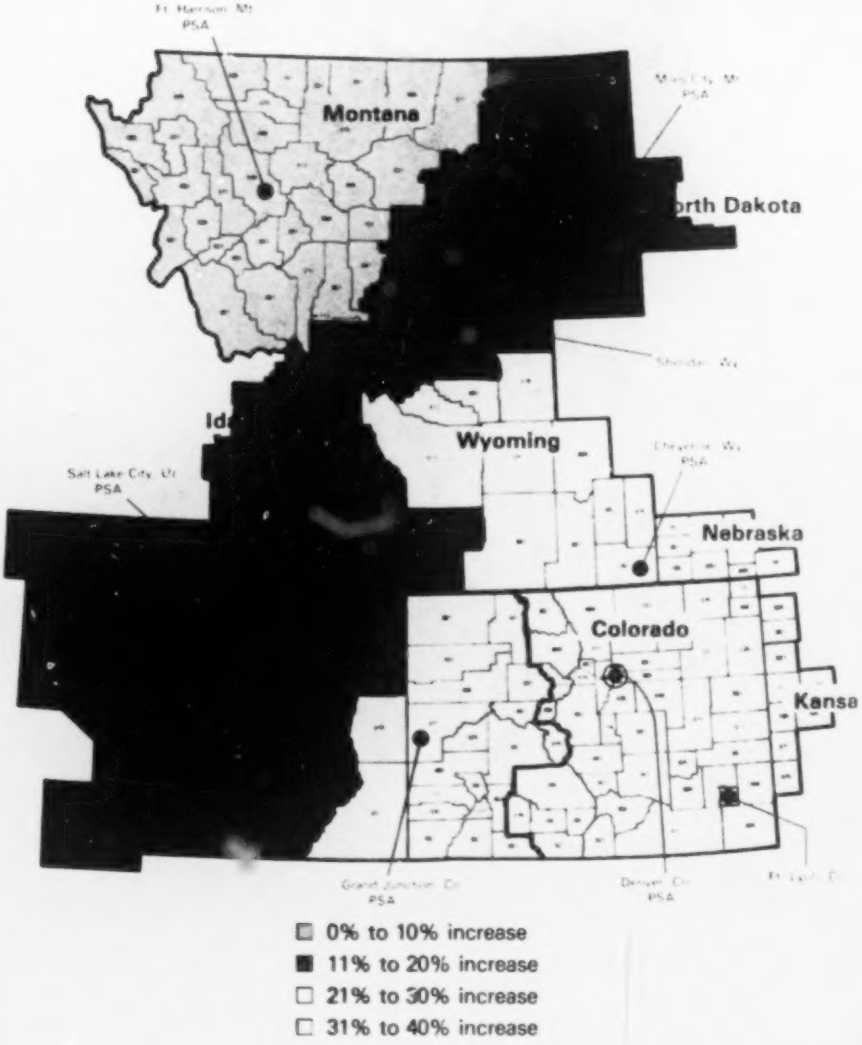
Medical District #24 — Primary Service Areas


Ft. Harrison, Mt
PSA
Montana
Miles City, Mt
PSA
North Dakota
Sheridan, Wy
Cheyenne, Wy
PSA
Salt Lake City, Ut
PSA
Grand Junction, Co
PSA
Denver, Co
PSA
Ft. Lyon, Co

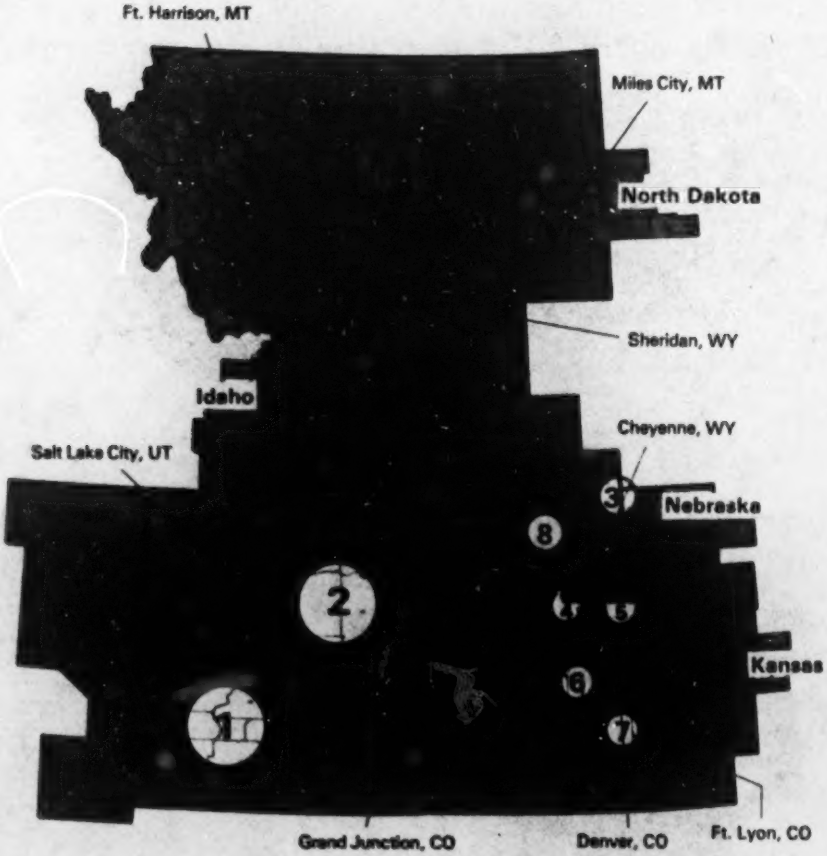
■ VAMC Salt Lake City (UT) PSA
■ VAMC Denver (CO) PSA
■ VAMC Cheyenne (WY) PSA
▨ VAMC Fort Harrison (MT) PSA
■ VAMC Grand Junction (CO) PSA
□ VAMC Miles City (MT) PSA

VAMC's at Fort Lyon and Sheridan are Psychiatric facilities which provide services for the entire Medical District

Medical District #24
Medical Center Primary Service Areas
Growth of Veteran Population, 1970-1980


Ft. Harrison, Mt. PSA
Montana
Miles City, Mt. PSA
orth Dakota
Sheridan, Wy.
Ida
Wyoming
Cheyenne, Wy. PSA
Salt Lake City, Ut. PSA
Nebraska
Colorado
Kansa
Grand Junction, Co. PSA
Denver, Co. PSA
Ft. Lyon, Co.
▨ 0% to 10% increase
■ 11% to 20% increase
☐ 21% to 30% increase
☐ 31% to 40% increase

Medical Center Outreach


Ft. Harrison, MT
Miles City, MT
North Dakota
Sheridan, WY
Idaho
Cheyenne, WY
Salt Lake City, UT
Nebraska
3
8
2
4
5
Kansas
6
1
7
Grand Junction, CO
Denver, CO
Ft. Lyon, CO

- ● Tertiary Medical Centers
- ▣ Psychiatric Medical Centers
- • Secondary Medical Centers

Existing Sites ○

1. Richfield, UT
2. Roosevelt, UT
3. Torrington, WY
4. Ft. Collins, CO
5. Ft. Morgan, CO
6. Colorado Springs, CO
7. Pueblo, CO
8. Laramie, WY

Medical District #24

VAMC Cheyenne, Wyoming

- Traveling Followup Clinics
  - Provide post-hospitalization followup of stable patients

  - Torrington, Wyoming - 80 miles northeast of Cheyenne

  - Laramie, Wyoming - 50 miles west of Cheyenne

  - VAMC staff travel to community, return to VAMC same day

  - Clinics held on alternate Fridays

  - 28 patient visits per month

  - Staffing: Nurse Practitioner, Clerk

Medical District #24

VAMC, Denver, Colorado

- Medivan Clinics
  - Ft. Morgan, CO - 79 miles northeast of Denver
    Ft. Collins, CO - 63 miles north of Denver
    Colorado Springs, CO - 67 miles south of Denver
  - VAMC staff travel to clinic site, return same day
  - Clinics held three days per week - one location per day
  - 260 patient visits per month
  - Staffing:
    Ft. Morgan and Ft. Collins - Physician, Nurse/technician
    Colorado Springs - Physician, Nurse Practitioner

Medical District #24

VAMC Fort Lyon, Colorado

- Outreach Followup Clinics
    - Provide medication reviews and followup care, limited physical examinations and referral; mental health services
    - Pueblo, Colorado - 90 miles west of Fort Lyon
    - VAMC-based traveling teams; clinics held at DAV Center
    - Medical Clinics - held every other week (1 ½ days)
      Mental Health Clinics - held once each week (1 ½ days)
    - Team composition: Coordinator and representatives from medicine or psychiatry, nursing, social work, psychology, and medical administration

Medical District #24

VAMC Salt Lake City, Utah

- Rural Health Outreach Clinics
    - Provide primary health care, referral, triage, and post-hospitalization followup
    - Richfield, UT - 160 miles south of Salt Lake City
    - Roosevelt, UT - 150 miles east of Salt Lake City
    - Staffed by VAMC employees who live in the community in which clinic is located
    - Both clinics are open 5 days per week
    - Richfield - 253 patient visits per month

      Roosevelt - 189 patient visits per month
    - Staffing at each clinic:

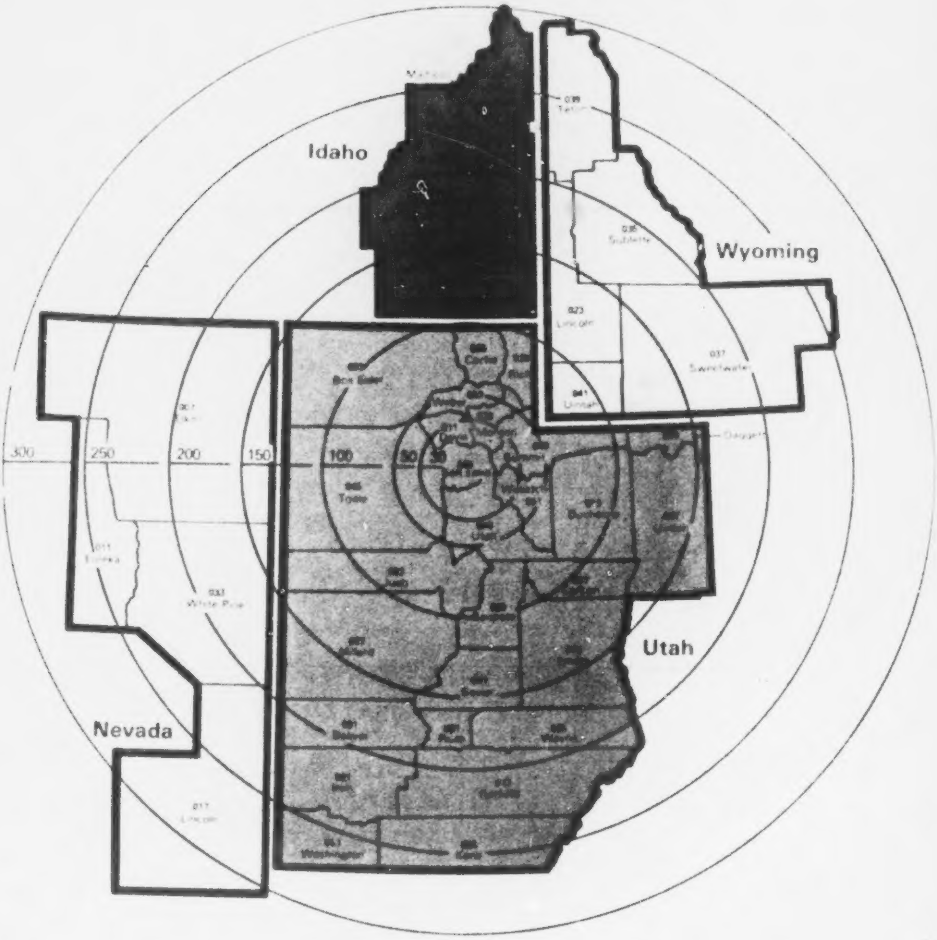
      Physician (part-time),
      Physician Assistant,
      Clerk/Typist

Veterans
Administration

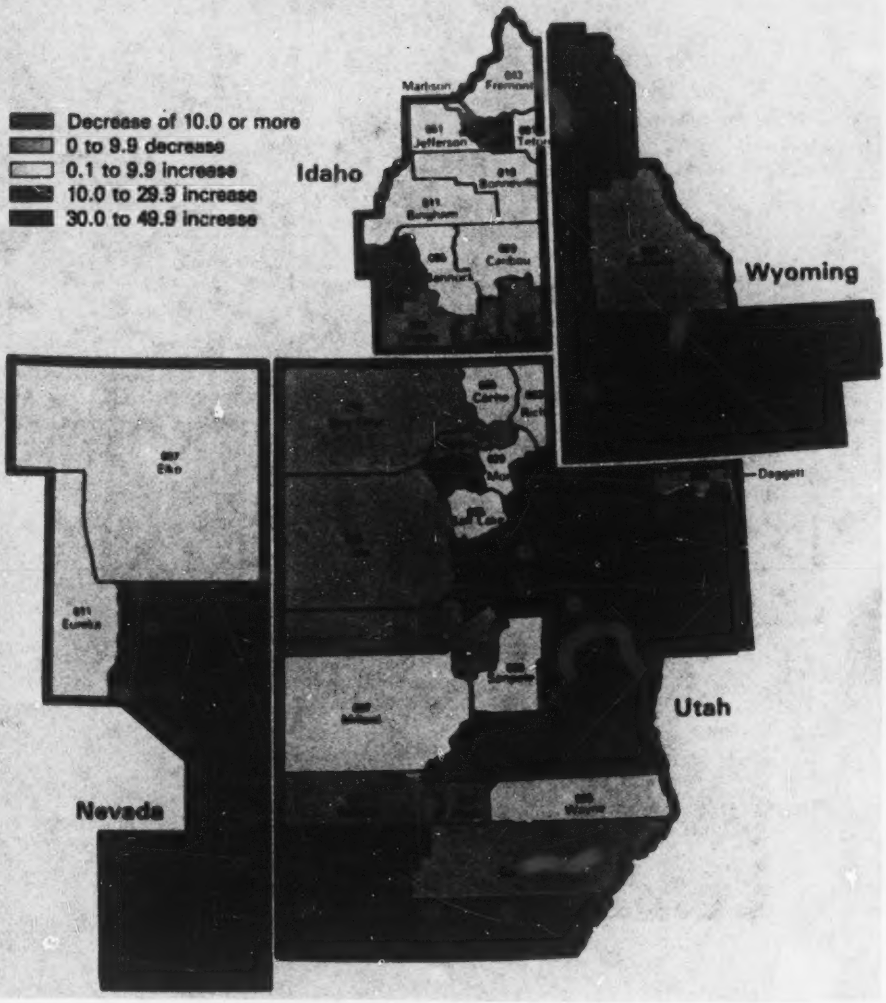
Current VAMC SLC
Pilot Rural Outreach Efforts

Rural Health Care Clinics

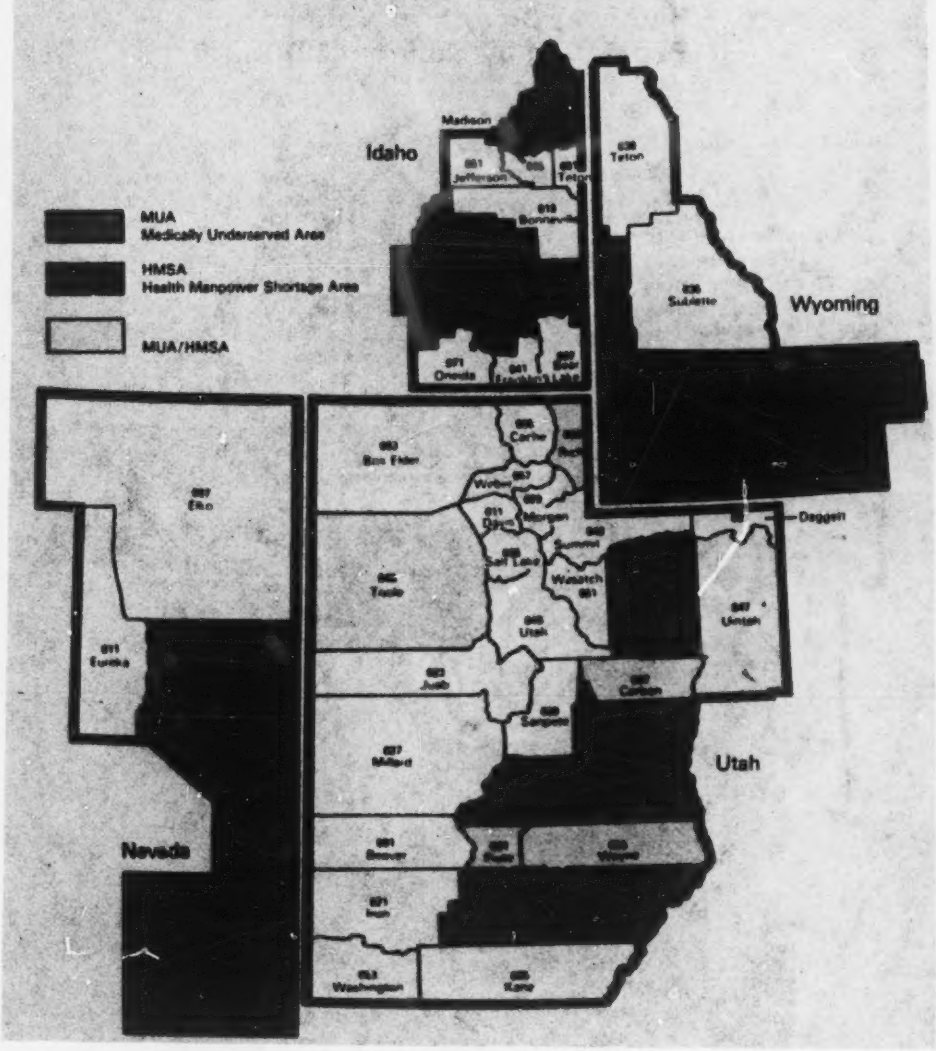
VAMC Salt Lake City
Primary Service Area


Idaho
Wyoming
Utah
Nevada
039
Teton
035
Sublette
023
Lincoln
037
Sweetwater
041
Uintah
Daggett
007
Elko
011
Eureka
033
White Pine
017
Lincoln
300
250
200
150
100
50
30
Box Elder
Tooele
Utah
Sevier
Washington
Kane

VAMC Salt Lake City Primary Service Area Showing Growth of Veteran Population by County - 1970-1980


■ Decrease of 10.0 or more
▨ 0 to 9.9 decrease
☐ 0.1 to 9.9 increase
▨ 10.0 to 29.9 increase
■ 30.0 to 49.9 increase
Idaho
Wyoming
Nevada
Utah
Madison
Fremont
Jefferson
Teton
Bonneville
Bingham
Bannock
Caribou
Elko
Eureka
Cache
Rich
Morgan
Salt Lake
Daggett
Sanpete
Millard
Wayne

**VAMC Salt Lake City
Primary Service Area**


Madison
Idaho
Jefferson
Teton
Bonneville
Oneida
Franklin
Bear Lake
Teton
Sublette
Wyoming
MUA
Medically Underserved Area
HMSA
Health Manpower Shortage Area
MUA/HMSA
Elko
Eureka
Nevada
Box Elder
Cache
Rich
Weber
Davis
Morgan
Summit
Salt Lake
Tooele
Wasatch
Utah
Daggett
Uintah
Juab
Carbon
Sanpete
Millard
Utah
Beaver
Piute
Wayne
Iron
Washington
Kane

Definition of Designations Used by the Department of Health and Human Services

Medically Underserved Area (MUA)

Designation is based upon:

- Number of physicians per 1,000 population
- Infant mortality rate
- % of population over age 65
- % of population below poverty

Health Manpower Shortage Areas (HMSA)

Designation as a primary HMSA are:

- The area is a rational area for the delivery of primary medical care services
- One of the following applies:

  Area has ratio of population-to-primary care physicians of at least 3,500:1; or

  Area has a ratio or population-to-primary care physicians of less than 3,500:1 but greater than 3,000:1 *and* has either unusually high needs *or* insufficient capacity of existing primary care providers
- Primary medical care manpower in contiguous areas are overutilized, excessively distant, or inaccessible to the population

Note: When all criteria are met within an area, it is considered to be *both* medically Underserved and an area of Health Manpower Shortage.

VAMC Salt Lake City Rural Health Outreach Clinics

- Non-traditional health care delivery model currently being researched by VAMC Salt Lake City
- Provide primary health care, triage, referral, and post-hospitalization followup care to veterans who reside in rural areas located more than 75 miles from Salt Lake City
- Areas served are officially designated by Department of Health and Human Services as being medically underserved and/or health manpower shortage areas; existing health care resources are impacted by population growth; and obstacles to travel and access to health care are of particular concern
- Emphasis on non-interference in Areas' existing health care delivery systems. High level of community support
- Services provided through small, community-based clinics, staffed by VAMC employees who live in the community in which the clinic is located
- Two demonstration model clinics activated in Fall 1982:

  Roosevelt, UT - 150 miles east of Salt Lake City
  Richfield, UT - 160 miles south of Salt Lake City
- Evaluation of demonstration model clinics underway. Formal health services research project has been submitted for funding
- Additional areas of VAMC's Primary Service Area have been identified as potential locations for additional clinics, pending results of evaluation of demonstration models

VAMC Salt Lake City Rural Health Outreach Clinics

Potential Advantages to the VAMC

- Savings in beneficiary travel
- Savings in cost for fee-basis care for service-connected veterans
- Shorter hospital stays
- Decrease in hospital readmission rates
- Decrease in number of unnecessary VAMC specialty clinic visits
- Identification of illness in early stages, when intervention is less costly and medical crises more easily avoided
- Treatment of veteran at most appropriate level of care

Potential Advantages to the Veteran

- Decrease in time lost from work because of travel to VAMC
- Savings in costs for travel and lodging for family to accompany veteran to VAMC
- Savings in costs associated with hiring help to perform necessary farm chores in veteran's absence
- More frequent followup visits allow closer monitoring of illness and avoidance of costly medical emergencies

VAMC Salt Lake City Rural Health Outreach Clinics

Quality of Care - Improved Patient Outcome Potential

- Continuity of health care. VAMC medical staff provide care prior to and during hospitalization and following hospital discharge
- Closer monitoring of changes in veteran's medical status
- Early intervention, prior to development of medical crises
- Immediate availability of specialty and sub-specialty consultation
- More frequent reinforcement of patient education, and monitoring of compliance with treatment regimen
- Decreased episodes of hospitalization
- Medical and educational support encourage family to care for debilitated veteran at home, avoiding institutionalization
- VA care providers more knowledgeable about unique medical problems of veterans, i.e., POW's Vietnam veterans, toxic and radiation exposure
- Provision of care to veterans who previously went without medical care because of obstacles to accessing it
- More personalized care; greater involvement of patient and family in treatment planning
- Increased patient satisfaction and compliance

VAMC Salt Lake City

Rural Health Outreach Clinics — Site Selection Factors

- Central to large trade areas
- Surrounding small "cluster" communities
- Near other "cluster" communities
- Distances greater than 75 miles from VAMC
- Adequacy of public transportation
- Climate and geographical barriers

Availability of non-VA health care resources

- Health manpower shortage areas
- Medically underserved areas
- Overloaded resources
- Basic "core" resources present

Acceptance of the Presence of a VA Clinic

- Community leaders
- Physicians/other medical community
- Veterans
- Veterans service organizations

Rural Health Outreach Clinics – Major Diagnoses

- Arthritis
- Heart Disease
- Respiratory
- Vascular
- Skeletal
- Renal
- Gastrointestinal

VAMC SALT LAKE CITY - RURAL HEALTH OUTREACH CLINICS
WORKLOAD EXPERIENCE TO DATE - DEMONSTRATION MODEL CLINICS

ELEMENT	RICHFIELD (11/15/82-5/31/83)	ROOSEVELT (9/13/82-5/31/83)	TOTAL--BOTH CLINICS
TOTAL NUMBER OF VISITS	1,507	1,556	3,063
TOTAL NUMBER PATIENTS	405	459	864
PATIENT AGE GROUPS	20-40 years - 39 41-60 years - 190 61-70 years - 142 71-80 years - 26 81+ years - 8 TOTAL 405	20-40 years - 87 41-60 years - 208 61-70 years - 146 71-80 years - 8 81+ years - 10 TOTAL 459	20-40 years - 126 41-60 years - 398 61-70 years - 288 71-80 years - 34 81+ years - 18 TOTAL 864
PERCENT OF PATIENTS WHO DO NOT HAVE HEALTH INSURANCE	55%	78%	67%
RURAL CLINIC PATIENTS REFFERED TO MEDICAL CENTER	Referred For: Admissions - 35 VAMC Clinic- 87	Referred For: Admissions - 49 VAMC Clinic- 81	Referred For: Admissions - 84 VAMC Clinic- 168
PERCENTAGE OF PATIENTS REFERRED TO MEDICAL CENTER--ANY REASONS	30%	28%	29%

RURAL HEALTH OUTREACH CLINICS - MODEL SITE

RICHFIELD, UTAH

AREA SERVED:

COUNTY	COUNTY POPULATION	VETERAN POPULATION	COUNTY AREA (SQ. MILES)
Millard	8,970	970	6,648
Piute	1,329	138	753
Sanpete*	14,620	1,568	1,597
Sevier**	14,727	1,555	1,934
Wayne	1,911	213	2,489
Juab	5,530	653	3,412
	47,087	5,097	16,833

---

*Sanpete Valley population is expected to double by 1990.

**Richfield, County Seat of Sevier County, population to increase by 51% by 1990.

DISTANCE FROM SALT LAKE CITY: Richfield - 160 miles.

DISTANCE FROM RICHFIELD TO OTHER COMMUNITIES IN AREA: Richfield is the hub of a trade center which contains 17 communities within a 60 mile radius.

TRANSPORTATION FACTORS: The area is served by bus transportation only, and this services only communities situated on the only north-south highway. There is no public transportation between small communities and the cities served by the bus system. There is no rail transportation nor air service except for chartered small aircraft. Severe weather conditions make travel hazardous between late October and late March.

Veteran Service Organizations are active in the area and provide high level of support. Additionally, the area's physicians and community leaders are supportive of efforts to establish a VA presence in health care delivery.

INDUSTRY: Agriculture, dairying, ranching, turkey processing, mining, milling, power production and sheetrock production.

HEALTH CARE RESOURCES AVAILABLE IN THE AREA: Sevier County, and Fillmore in Millard County, have been designated as Health Manpower Shortage Areas by the Department of Health and Human Services.

CARE PROVIDERS: Richfield is served by 6 Family/General Practitioners, 1 Psychiatrist, and 1 Radiologist; 1 Family Nurse Practitioner. It is recruiting for an Orthopedic Surgeon. The eastern part of the geographic area (Sanpete Valley) is served by 6 physicians--2 Family/General Practitioners in Ephraim/Moroni, 3 Family/General Practitioners in Mount Pleasant, and 1 General Practitioner in Manti. Sanpete Valley is actively recruiting a General Surgeon. Fillmore (Millard County) is served by 2 Family Physicians with ongoing recruitment for a third. Nephi is served by 3 Family/General Practitioners and one Nurse Practitioner.

HOSPITALS: Juab County is served by the 27-bed Juab County Hospital. Sevier County is served by the 28-bed Sevier Valley Hospital owned and operated by Intermountain Health Care, Inc. IHC also operates the 22-bed Fillmore Hospital in Millard County and the 25-bed Sanpete Valley Hospital.

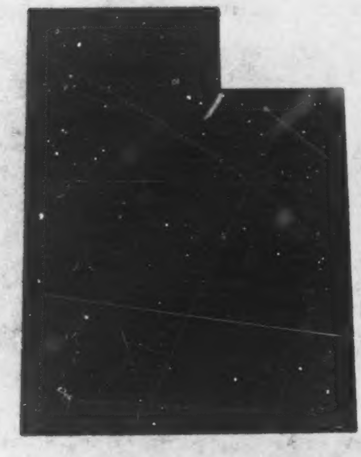
RATIONALE FOR SELECTION AS MODEL SITE: Richfield is the geographical and trade center for the south-central area of the State of Utah. Its service population of 20,000 contains a significant number of veterans, many of whom are self-employed in agriculture and agriculture-related occupations who are unable to pay the cost of medical care in their communities. The area is remote from the VAMC Salt Lake City. Lack of an adequate public transportation system compounds the problem of distance and makes access to the VA Health Care System impossible for many veterans. Older veterans, especially, are unable to drive to Salt Lake City for health care and return to their home the same day. Round trip travel time is 7 hours by car; the bus schedule requires the veteran to leave his home at midnight to travel to Salt Lake City for an appointment the following day, and he could not leave Salt Lake City for the 4-hour return trip until 7:45 p.m.

The area has been severely impacted by energy-related development and health care resources have been unable to meet the demands of the rapidly growing population.

The State's Combined Veterans Field Service Officer's Outreach Program experiences the second-largest number of complaints concerning lack of availability of VA Health Care from this area.

RURAL HEALTH OUTREACH CLINICS - MODEL SITE

ROOSEVELT, UTAH



AREA SERVED:

COUNTY	COUNTY POPULATION	VETERAN POPULATION	COUNTY AREA (SQ. MILES)
Daggett	769	76	708
Duchesne	12,565*	1,184*	3,260
Uintah	20,506*	2,141*	4,476
Carbon	22,179	2,649	1,474
TOTAL:	56,019	6,050	9,918

---

*Population figures do not include influx of workers into the area because of oil and oil shale development--exact figures not available. Population expected to double by 1990.

DISTANCE FROM SALT LAKE CITY: Roosevelt - 146 Miles

DISTANCE FROM ROOSEVELT TO OTHER COMMUNITIES IN AREA: Other communities (approximately 22) are within a 50 mile radius, with the exception of Carbon County communities which are 80 miles from Roosevelt.

TRANSPORTATION FACTORS: The area is served by bus transportation on a twice-daily basis. However, many veterans must drive distances up to 20 miles between their home and a community where there is a bus stop, and it is generally easier for them to continue on into Salt Lake City by private vehicle. Highway 40 links the area to Salt Lake City; it is primarily a 2-lane mountain road, and during the winter months, snow can close the three mountain passes for periods of time. Blowing and drifting snow and ice make travel hazardous between early October and mid-April. In good weather, travel time between Roosevelt and Salt Lake City is three hours. There is no railroad service to the area. Vernal has a small commercial airport served by a commuter airline. While several flights are available daily, the cost is $64 one way. The greatest percentage of the area's veterans live more than 30 miles from Vernal. Because of the inconvenience in driving to Vernal, the high cost of the air fare, and the cost of taxi between the Salt Lake City airport and the VA Medical Center, air travel is simply not a viable alternative for veterans who need to reach Salt Lake City.

INDUSTRY: Agriculture, ranching, oil industry (including oil shale and tar sand development), and lumbering.

HEALTH CARE RESOURCES AVAILABLE IN THE AREA: Uintah and Duchesne Counties have been designated as Health Manpower Shortage Areas by the Department of Health and Human Services.

CARE PROVIDERS: Roosevelt has 3 Family/General Practitioners and 1 Obstetrician/Gynecologist; 2 Physician Assistants. They are actively recruiting for 4 additional Family Physicians. Vernal has 6 Family/General Practitioners, 1 General Surgeon, 1 Orthopedic Surgeon, 3 Physician Assistants, and 2 Family Nurse Practitioners. They are actively recruiting for 8 additional physicians. None of the other communities within the area have physicians. Duchesne City has 2 Family Nurse Practitioners.

HOSPITALS: Only Roosevelt and Vernal have hospitals. Roosevelt is served by the 32-bed Duchesne County Hospital, owned and operated by Duchesne County; Vernal is served by the 36-bed Ashley Valley Medical Center, owned and operated by Hospital Corporation of America.

RATIONALE FOR SELECTION AS MODEL SITE: Roosevelt is the geographical center of the Uintah Basin. While the city has a population of only 3,842, its service population is 20,000; when combined with the service population of Vernal (30 miles east of Roosevelt), it provides services to a significant number of veterans in the northeast quarter of the State of Utah. The area is isolated from metropolitan Salt Lake City and the VA Medical Center there by mountain ranges which make travel difficult. Problems of accessibility to the VA Health Care System are compounded by lack of public transportation systems.

The area has been severely impacted by energy-related development and the limited health care resources have been over-taxed by the rapidly growing population. Not only do veterans have difficulty accessing the VA Health Care System, they frequently encounter problems accessing any health care system.

The area is one from which the Combined Veterans Field Service Officers' Outreach Program receive the greatest number of complaints from veterans regarding the inaccessibility of VA health care.

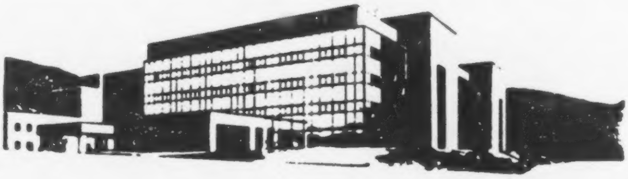
A high level of support for a VA Rural Health Outreach Clinic is evident among community leaders, community physicians, and veterans' service organizations in the area.

VAMC Salt Lake City — Rural Health Outreach Clinics Future Directions

- Adult day care center
- Expanded health education
- Training sites for physicians, physician extenders, nurses, and allied health
- Rural hospital-based home care
- Specialty clinic visits

Veterans
Administration

Rural Health Outreach Clinics Evaluation



VAMC Salt Lake City Rural Health Outreach Clinics — Evaluation

Additional experience and data are needed to thoroughly evaluate the program's socioeconomic and institutional impact and its feasibility.

Factors to be measured include:

- Cost of treating the veteran in the rural clinics versus the cost of treating him/her at VAMC Salt Lake City
- Cost of treating the veteran through the rural clinics versus the cost of treating him/her through other outreach models
- The quality of care which can be provided in the rural clinics
- Cost savings resulting from early intervention into developing disease states
- Changes in "quality of life" for veterans who have easier access to medical care, particularly as it affects employability
- The acceptability and effectiveness of the use of physician extenders
- The impact of the clinics upon the community in which they are located, and the degree of community support and commitment to clinic success

VAMC Salt Lake City Rural Health Outreach Clinics — Evaluation

VAMC Salt Lake City has submitted a pre-proposal for a health services research project to evaluate its Rural Health Outreach Clinics. The proposed project is the first in a series of such projects planned to evaluate the socioeconomic impact of the clinics. Future projects will include the comparison of cost and quality among the various outreach models being piloted in Medical District #24. The following abstract is taken from the proposal submitted to VA Central Office Health Services Research Service July 1, 1983.

Evaluation of Innovative Systems For Ambulatory Health Care

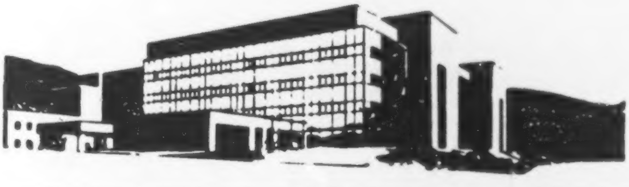
Charles B. Smith, M.D., Ina J. Curtis,
Robert Richardson, P.A.-C.
VAMC, Salt Lake City, UT 84148
Investigator-Initiated Research Program

Abstract

The Salt Lake City VAMC has established two demonstration sites of an innovative system of health care delivery in its primary service area (PSA). This system, the Rural Health Outreach Clinic (RHOC), was developed in an effort to prove more accessible and cost-effective service to veterans in outlying communities. The proposed research is designed to compare RHOC's with the VAMC from the standpoint of (1) patient access to care, as indicated by utilization of services and satisfaction with care; (2) certain preliminary measures of quality of care, such as appropriateness of referral and patient compliance with referral from an RHOC to the VAMC; and (3) dollar costs of care per treatment episode, holding severity of disease and quality of care constant. Primary sources of data include veterans in the PSA, VA fiscal records pertaining to patient treatment, and medical records of selected patients. Data on out-of-pocket costs and satisfaction with care will be solicited from 1000 veterans (250 patients seen in each RHOC and 500 seen in the VAMC) by questionnaire and interview over the course of one year. Information about quality of care will be obtained from an audit of 500 medical records of patients seen in the RHOC's, using criteria for referral developed by a panel of physicians. VA dollar costs will be obtained from fiscal records. Descriptive, multivariate, and cost-effectiveness analysis will be performed with standard computer statistical program packages (SAS, SPSS, and BMDP.)

Veterans
Administration

Medical District #24
Potential Outreach Efforts



VAMC SALT LAKE RURAL HEALTH OUTREACH CLINICS PROGRAM
POTENTIAL MODEL CLINIC AREAS

AREA TO BE SERVED	CLINIC LOCATION/ POTENTIAL LOCATION	COUNTIES SERVED	NUMBER OF SQ. MILES	VETERAN POPULATION	DISTANCE FROM VAMC SALT LAKE
Southwestern Utah	Cedar City or St. George	Beaver, Garfield, Iron, Kane, Washington	17,634	5,875	313
Southwestern Wyoming	Rock Springs or Greenriver	Lincoln, Sublette, Sweetwater, Uintah*	12,583	9,597	190
Southeastern Idaho	Idaho Falls or Pocatello	Bannock, Bingham, Bonneville, Caribou, Jefferson, Madison, Fremont, Power, Teton in Idaho,+ Teton in Wyoming	14,910	25,919	225
Eastern Nevada	Elko	Elko, Eureka, Lincoln, White Pine	40,897	4,454	245
East-Central Utah	Price	Carbon, Emery	5, 916	3,878	135

+Bear Lake, Franklin, and Oneida Counties in Idaho are excluded, as they are closer to VAMC Salt Lake City than to Idaho Falls. Teton County, Wyoming is included in above figures.

*Teton County, Wyoming is included in Idaho because of its proximity to Idaho Falls.

Potential Rural Health Outreach Activities

VAMC Miles City, Montana

Billings, Montana is being considered as a potential site for a free-standing outpatient clinic

- 150 miles west of Miles City VAMC; 135 miles northwest of VAMC Sheridan, Wyoming
- Would provide primary care and post-hospitalization followup services to veterans in south-central Montana and north-central Wyoming

VAMC Cheyenne, Wyoming

Three sites are being considered as potential Traveling Followup Clinic sites:

- Sidney, NE - 87 miles east of Cheyenne
  Casper, WY - 180 miles northwest of Cheyenne
- Would provide medication supervision and post-hospitalization followup care to medically stable patients

INNOVATIVE HEALTH CARE DELIVERY SYSTEMS WITHIN MEDICAL DISTRICT 24

Prepared by:

Medical District 24

I. ABSTRACT

The trend in innovative health care delivery systems in Medical District 24 is toward providing care needed at a location most convenient to the patient. This must be accomplished within the constraints of resources available, cost effectiveness, quality assurance, and veteran eligibility requirements.

The original motivation was to achieve realistic reductions in the beneficiary travel expense related to long-distance transportation of patients for relatively minor, but necessary, treatment episodes. The more recent important motivating factors have been patient convenience and the need to provide equitable accessibility to the VA Health Care System. It has been observed, for almost three years, to be less expensive to transport treatment teams to a distant clinic location, which has been scheduled in advance, than it is to transport several patients to the central medical facility. While it may be somewhat inconvenient for the physician, nurse, etc., the patient finds it considerably more convenient in relation to employment, personal schedules, and time away from home.

Some of the most innovative and cost effective aspects of medical outreach have come from the various modes of outreach devised by the treatment specialists themselves. A variety of mechanisms have been utilized from charter airlines, commercial airlines, motor vehicles, and a combination of team and patient travel to a neutral location, to the hiring of physician extenders and local physicians in establishing rural clinics.

It is anticipated that some of these projects may demonstrate the need for new or adoptable technologies not presently utilized in hospital care. With the introduction of great distances between the treatment teams and home base, needs for communication, scheduling, lightweight sophisticated equipment, less complex procedures and a need for increased patient confidence and satisfaction become critical factors. The lack of immediate access to the full range of hospital-based diagnostic capabilities and treatment modalities places the team in a new environment which tends to produce more treatment oriented methods and procedures. The overall result may possibly be a more discriminating attitude on the part of team members toward increasingly efficient treatment programs for each patient. Elimination of unnecessary but convenient tests and procedures may likely be one significant benefit of these innovative delivery systems.

The geographical size and topography of the Medical District presents serious obstacles to the veteran residing in isolated rural areas who wishes to access the System. The same factors seriously drain medical centers' budgets when beneficiary travel must be paid to transport patients distances up to 480 miles for medical care.

The following reflects critical needs for innovation faced by Medical District 24, the goals and objectives, alternative approaches devised and implemented, affiliation support of these ventures, and an analysis of the impact of these innovations and salient related issues for consideration.

II. STATEMENT OF NEED

Geographically, Medical District 24 is much larger than any other district, as well as being larger than 3 of the 6 DM&S Regions, within the current VA structure.

Medical District 24 covers 14% of the Continental U.S. land area; however, only 2.5% of the total Continental U.S. population is within the District boundaries. Attachments 1 - 3 illustrate the geographical size and dispersion obstacles Medical District 24 must deal with in providing health care to the veteran patient.

The medical centers within Medical District 24 are separated by great distances from each other due to the geographical expanse of the District. The District is also sparsely populated, with great distances between populated areas of any size. The relatively long distances for travel within the PSAs, as well as between VAMCs, translates into unusually large beneficiary travel expenses within Medical District 24. This large expanse has been of major concern throughout the District and has been a prime motivator to develop innovative approaches to reduce patient travel expenses and to use the travel money saved to improve patient care.

Several of our medical centers are located in remote, small communities seriously lacking in educational offerings and medical specialists, either in-house or by fee basis consultation. This limits both the number of prospective employees and professional services available through these medical centers. Innovative approaches must be utilized to meet the patient care needs of the veteran patients residing within these areas.

Six of the eight medical centers within the District are non-affiliated, remotely located, and isolated by great distances from metropolitan clinical and educational bases. It is extremely difficult for these medical centers to recruit and retain competent staff at the more highly trained levels. Innovative approaches to obtain these services from other medical centers through various sharing arrangements are essential to patient care.

Veterans residing in these widely dispersed and isolated communities are afforded little opportunity to receive VA medical care because of nearly overwhelming obstacles to accessing the system. Within Medical District 24, only a limited number of veterans in the rural areas persist in their attempts to overcome the obstacles and travel to one of the medical centers to take advantage of the benefits for medical care to which they are entitled. The failure of these veterans' attempts to access the system is demonstrated by statistics which show that the majority of patients who receive hospital inpatient treatment live within a 100 mile radius of the medical centers.

Because of the above, Medical District 24 has devised innovative approaches, beyond the traditional ones, to meet patient care needs within the constraints of cost effectiveness, quality assurance and veteran eligibility requirements.

III. MEDICAL DISTRICT GOALS AND OBJECTIVES

Medical District 24 major goals and objectives in devising and implementing innovative approaches in the delivery of health care are as follows:

- To continually explore cost effective, innovative means and methods to bridge the distance gaps and to reduce beneficiary travel costs in meeting patient care needs at an appropriate level of care.

- To bring specialized health services to a more convenient location for the veterans who increasingly find it more difficult, due to personal commitments and age, to travel great distances for the medical care.
- To demonstrate that clinical skills and educational opportunities can be effectively shared amongst District facilities.
- To provide tertiary care support to other medical centers to expand the level of patient services they offer.

IV. ALTERNATIVE APPROACHES

The following reflects a variety of Innovative Health Care Delivery System approaches utilized in Medical District 24.

Tertiary Outreach Clinics are held at non-affiliated medical centers. Only "surgical problem" and "medical problem" patients requiring specialist skills are to be scheduled for these clinics. These individuals are patients of the nearest medical center to their home which is responsible for their medical care, diagnostic exams (either accomplished in-house or through fee basis) and beneficiary travel to and from these clinics. The clinics are conducted by specialty teams from the tertiary medical centers sent out on a scheduled basis via chartered plane, commercial airlines, and vehicles to conduct these clinics and to facilitate the care of veteran patients by the most cost effective means possible. The chartered aircraft which transport specialists to clinic sites also carry patients, on a space available basis, between the tertiary medical center and clinic sites.

Tertiary Outreach Clinics have been established for the purpose of:

- Providing specialized outpatient follow-up care for patients who have been treated by a tertiary medical center and transferred or discharged back to their home VAMC.
- Screening non-emergent patients who may need further specialized care at a tertiary medical center.
- Providing a patient and physician consultation.
- Doing minor diagnostic studies.

The Salt Lake City VAMC conducts Tertiary Outreach Clinics at the Fort Harrison VAMC (Montana) in Neurosurgery, Ophthalmology, Optometry, Orthopedics, Urology and Vascular Surgery. Miles City VAMC (Montana) patients are seen at Fort Harrison, thus reducing the cost of transportation for specialized care. These clinics were established during May-September 1980 to reduce beneficiary travel expense for Montana veterans. An average of 6.0 clinics are held a month. Occasionally extra clinics are scheduled and some are cancelled depending on the workload and weather conditions.

The Salt Lake City VAMC also conducts Tertiary Outreach Clinics at the Grand Junction VAMC (Colorado) in ENT, Neurology, Neurosurgery, Ophthalmology, Optometry, Physiatry and Urology. Some of these clinics started in the early 1970's at the request of the Grand Junction VAMC while three began just recently. An average of 6.5 clinics are held a month. Occasionally extra clinics are scheduled and some are cancelled depending on the workload.

Attachments 4, 5, and 7 show the location, activities and savings associated with the Tertiary Outreach Clinics.

Tertiary Outreach Support Services are provided to non-affiliated medical centers in expanding the level of patient services offered at these facilities.

There is a chartered flight weekly between Denver and Fort Lyon (Colorado) to send professionals from the Denver VAMC to provide needed clinical support care to the Ft. Lyon Patients. Two Psychiatrists and one Podiatrist spend 1 day per week at Ft. Lyon and Orthotics provides service to Ft. Lyon two days a month. Also, other Denver VAMC staff members travel intermittently at the request of Ft. Lyon to provide needed services and assistance. The remote, isolated location of Ft. Lyon makes it very difficult to recruit and retain needed professional expertise. It is also noted that the need for specialized care at a long-term psychiatric facility, such as Fort Lyon, is more limited in comparison to that required in an acute GM&S facility, and even if it were possible to recruit the highly specialized medical personnel, it is more cost effective to obtain these services in the present manner.

The Denver VAMC sends a representative from its Prosthetics Service 1 day a month to conduct a Prosthetics Clinic at the Grand Junction VAMC. Denver's Prosthetic Service measures patients for prosthesis, fabricates and repairs prosthesis, consults on difficult/special cases, etc., in assisting Grand Junction meet a significant portion of the prosthesis needs of their patients. The Denver VAMC is the Clinic of Jurisdiction for the state of Colorado for fee basis, including prosthetics.

MediVAn Outreach Clinics have been established primarily to provide follow-up primary care to discharged veterans who reside considerable distances from the VAMC.

Over 2 years ago, the Denver VAMC established a Mobile Internal Medicine Clinic (MediVAn) to provide access care to primary care for veterans living more than fifty miles from the medical center. A 30 foot van was purchased and equipped as an internist's office. The van consists of the following three functional areas: the front area with driver and passenger seats and a small waiting area; the examining room; and the rear area containing a small laboratory, toilet, sink, and storage space for prepacked drugs.

The MediVAn is on the road 3 days a week seeing patients in Greely, Colorado (53 miles north), Ft. Morgan, Colorado (79 miles northeast), and Ft. Collins, Colorado (63 miles north). The MediVAn parks at Veterans' service organization facilities that provide electrical hook-ups for the MediVAn and a check-in and waiting area for the patients. Sites were selected based on distance from Denver and number of veterans in the area. This same MediVAn team started the Colorado Springs Clinic from the van and have continued the same services within the free-standing clinic after a building was located.

The MediVAn is staffed by the following three permanent employees: a physician, a health technician, and a coordinator. Physician responsibility is shared among the full-time ambulatory care staff at the Denver VAMC, all of whom are board-certified internists and members of the University of Colorado School of Medicine faculty. Each internist goes to the same MediVAn site every other week to establish his or her patient population and to maintain continuity of care. The MediVAn is driven by the health technician, who is responsible for overall maintenance of the van, check-in and check-out of patients, drawing blood, giving injections, and serving as liaison with local service organizations. The MediVAn coordinator acts as the office manager at the Denver VAMC and is responsible for appointments, obtaining charts from the file room, purchasing and supplies, serving as liaison with the clinical laboratory and pharmacy, and maintaining records for research and cost analysis.

The MediVAn was established on an appointment-only basis. Appointment cards are maintained by the coordinator, who receives referrals from primary care providers at the Denver VAMC, ward discharges from the Denver VAMC, veterans service officers at the MediVAn sites, and patients who call in after hearing about the MediVAn through friends or the media. Since medical records are maintained at the Denver VAMC and transported with the MediVAn for appointments, walk-in patients are seen without the benefit of records and are therefore discouraged. However this policy was enforced at the discretion of the individual physician and there is variability in the number of walk-in patients seen at the various sites. Emergencies are referred to the nearest local emergency facility. When a patient becomes ill between MediVAn visits he contacts his physician in Denver, who determines whether the patient can wait until the next MediVAn visit, should be seen sooner in Denver, or should be referred to the nearest hospital emergently.

In the first two years of operation there were 3,128 visits by 509 veterans with a mean age of 56 years, with 3.9 diagnoses, and receiving 3.0 medicines (These figures exclude those for Colorado Springs). The two year average cost per MediVAn visit was $68 ($78 for 1st year, $60 for 2nd year) compared with $67 per outpatient visit at Denver VAMC. The Denver VAMC has concluded that a mobile medical clinic is a convenient/viable method of delivering primary care to remote areas and is comparable in cost to outpatient hospital visits or visits to private internist.

Attachments 4, 6 and 7 show the location, site characteristics, activities and cost savings associated with the MediVAn clinics.

Free-Standing Clinics are established in major population centers where a large number of veterans reside, and are justified by a requirement for significant primary care services.

The Denver VAMC opened a free-standing Outpatient Clinic in Colorado Springs, Colorado (67 miles south) in FY 81. It currently provides psychiatric services five days a week and medical services one day a week. The medical services are provided by the MediVAn staff who travel from Denver and operate out of the Clinic in place of the MediVAn service they previously provided. In addition, dental services will be provided five days a week starting in December 1982. The dental program was delayed due to recruitment and equipment installation problems. After hour emergency psychiatric coverage is provided by a sharing agreement with the Pikes Peak Mental Health Association located in the same building. Denver indicates the potential workload for this clinic is much greater than earlier projected. The clinic is expected to reduce high costs previously experienced by the Denver VAMC for fee dental work and beneficiary travel.

Attachments 4, 6 and 7 show the location, site characteristics and clinic activities and estimated annual savings for this clinic.

Billings, Montana (150 miles west of the Miles City VAMC, Montana - 135 miles Northwest from the Sheridan VAMC, Wyoming) is under consideration as a potential site for a free-standing outpatient clinic. See attachment 4 for the location of this site.

Rural Health Outreach Clinics are being established for the purpose of:

- Determining need for hospital care.
- Providing post-hospitalization follow-up care.
- Providing home health care for housebound veterans.
- Triaging prior to specialty clinic visits.
- Providing acute care/emergency triage.
- Health and nutrition education.

It is anticipated the Rural Health Outreach Clinic Program will result in the following:

- Savings in beneficiary travel.
- Shorter hospital stays.
- Decrease in unnecessary hospital readmission rates.
- Identification of illness states in early stages, allowing more effective medical intervention, and more favorable patient outcome.
- Decrease in the number of unnecessary outpatient clinic visits.
- Increased patient satisfaction with both the medical care they receive and with the Veterans Administration and its attempts to provide veteran benefis.
- Increased equity in services provided veteran beneficiaries in rural areas.

Rural Health Outreach Clinics provide primary health care, referral, and post hospital follow-up services to veterans residing in isolated rural areas. The geographic size and topography of Medical District 24 presents unique problems to these veterans, many of whom reside hundreds of miles from VA Medical Center-based services.

The problem presented by the long distances are compounded by the lack of public transportation services: a few locations are served by rail transportation; some of the cities have direct air service; other communities on the major north-south and east-west highways must rely upon bus transportation; those communities which are locted remote from these routes have to depend solely upon private vehicles for transportation to the nearest bus terminal. At its best, bus transportation is minimally acceptable due to infrequent and inconvenient schedules and the extended time required for bus travel. With very few exceptions, it is not possible for a veteran to travel from his home to the medical center for a clinic appointment or evaluation to determine his need for hospitalization, and return to his home on the same day, either by bus or by private car. The severe weather conditions which are experienced throughout the Medical District make travel difficult during the months between early October and late March. At times, during those months, roads are impassable up to 2-3 days at a time because of heavy snow and drifting, especially in the mountain passes.

Other factors which characterize Medical District 24 rural outreach locations include large areas which have been designated by the Department of Health and Human Services as being Medically Underserved Areas, or Health Manpower Shortage Areas. Many areas have been designated as both medically underserved and as having health manpower shortages. Health care delivery in these areas are further impacted by rapid population growth due to energy-related development.

The Salt Lake City VAMC designed the Rural Health Outreach Clinic Program in two phases; Phase I consists of establishment of "model"/demonstration Clinics, Phase II includes identification of additional potential Clinic sites throughout the VAMC's Primary Service Area. Development of Phase II sites will be based upon analysis of data and experiences at the model/demonstration sites. Two model/demonstration Clinics are presently operational; Roosevelt, in Northeastern Utah, and Richfield, in South-central Utah. A third site, in the Southwestern part of the State, at St. George or Cedar City, is in planning stages. All sites were selected because of their central location in a geographic area of the State with large numbers of veterans, because they are trade and social centers for their area, and because obstacles to travel and access to health care are of particular concern at these locations.

The Roosevelt Clinic opened September 1982 and the Richfield Clinic opened in November 1982. Each Clinic is staffed with a full-time secretary and a full-time Physician's Assistant. Physician services and supervision of the Physician Assistant is provided by either local physicians hired as part-time VAMC staff physicians, or by physicians based at the Salt Lake City VAMC. Supervision by VAMC-based physicians is provided both at the Clinic site by a traveling physician (part-time) and by immediate telephone consultation with staff physicians in the specialties and sub-specialties. The secretary is supervised by Medical Administration Service at the Medical Center.

Outreach Health Clinic physicians and physician assistants work closely with the VAMC medical staff to assure continuity of care for patients discharged from the hospital to be followed in the rural clinics. This allows closer monitoring of changes in the patient's medical condition and earlier referral to appropriate specialty clinics to avoid emergencies and the need for re-hospitalization. Also, the admission process for patients who require hospitalization is facilitated, and VAMC resources can be more appropriately utilized and scheduled, when triage is accomplished prior to the veteran's arrival at the Medical Center. The triage and workup performed in the Outreach Clinics assure that the patient enters VAMC treatment at the appropriate level of intensity of services and screens out those veterans who do not require Medical Center services, prior to the expenditure of travel funds. Decision points occur much earlier in the patient-evaluation process, resulting in a more efficient use of resources and a decrease in unnecessary services and beneficiary travel.

Communications and tracking of patients, between the Rural Health Outreach Clinics and the Medical Center, is accomplished through telephone and computer linkages, Medical records data and doctors' orders can be input from both Medical Center and Clinic sites, further assuring continuity of care and appropriate monitoring of critical data such as laboratory test results, drug profiles, and follow-up treatment plans and schedules.

A total of 609 visits have been made to the Roosevelt Clinic between Mid-September and December 31, and 244 visits were made to the Richfield Clinic in the six weeks it has been operational. 46% of veterans seen to date in both clinics are over age 60; 14 patients are over 81 years. These age groups are those for whom travel to the Salt Lake City Medical Center is particularly difficult, and who frequently are lost to follow-up until their disease has progressed too far for effective intervention to occur. The majority of patients in this age category who are being seen in the rural areas are still physically active, self-employed farmers and ranchers, and timely intervention in their disease processes allows them to remain a productive member of society beyond the normal retirement age. Identification of correctible orthopedic problems has resulted in the return to employment of two veterans previously considered medically disabled in the six week experience of the Richfield Clinic.

The overwhelming acceptance of the Outreach Health Clinics by the State's veterans and by the veterans organizaitons and the communities themselves, is in part due to the recognition of the higher quality of care received by the veteran when his care is no longer "fragmented" between what he receives at the VAMC in Salt Lake City and private health care providers located in multiple small communities in the geographic area in which he resides. The modest size of the Rural Outreach Clinics also allows the staff to provide more personalized attention to the veteran and a more comprehensive evaluation and documentation of his medical history, and his health education than can possibly be provided in the community's overloaded health care resources or even in the fast-paced tertiary care VAMC in Salt Lake City. While it is still too early to have hard data to demonstrate, it is the observation of Clinic staffs that the patient is more compliant with his treatment plan when patient education can be reinforced through more frequent monitoring follow-up visits. Some of these visits are simply a drop-in visit to report progress to the Clinic staff who have become a part of the veteran's social support network. It is expected that this kind of close follow-up will result in decreased episodes of hospitalization and significant savings in beneficiary travel expenditures.

The Outreach Clinics are also providing excellent demographic data upon which to base projections for future health care needs. The Clinics' patient population characteristics, including presenting complaints and diagnoses demonstrate potentially signficant differences from those of the urban population and may provide us with the capability to identify trends which are important to long-range planning.

Attachment 4 shows location of two Model/Demonstration Rural Health Outreach Clinics and one prospective Model/Demonstration site.

Traveling Follow-up Clinics provide post-hospital outpatient follow-up care at locations more accessible to the veteran. The purpose is to keep the veteran functioning within the community and minimizing his return to the medical center. These clinics are conducted at two-week or less frequency, and are conducted in facilities at the locations visited.

The Cheyenne VAMC started holding an outreach follow-up clinic every other Friday in Torrington, Wyoming (80 miles northeast) in March 1982 in a veteran service organization facility. All clinic patients are pre-scheduled; walk-in patients are referred to the Cheyenne VAMC. See Attachment 7 for projected savings for this clinic. Results from Cheyenne's experience with the Torrington Clinic to date reveal the following:

- A nurse practitioner and a MAS clerk can handle up to 14 patients on a clinic day. It does not appear necessary to send a physician.
- An average of 13 of the 14 patients scheduled per clinic show-up, a 93% show rate.
- Of the very few walk-ins seen at the clinic, some are accessing the DM&S system for the first time and none had emergent problems.
- Waiting time for clinic patients is 5 minutes compared to 45 minutes at the Cheyenne VAMC.
- Patient acceptance and satisfaction with the clinic has been excellent. The only complaints received are minor in nature centering around travel pay and/or a desire to combine shopping trips for wives with hospital outpatient visits.
- The more obvious needs in the near future are equipment and supplies to draw and transport blood to the medical center.

The Cheyenne VAMC is also considering Laramie, Wyoming (50 miles west), Casper, Wyoming (180 miles northwest) and Sidney, Nebraska (87 miles east) as possible Outreach Follow-up Clinic sites. See Attachment 4 for location of the one new and three prospective Traveling Follow-up Clincs.

The Ft. Lyon VAMC started holding outreach follow-up clinics in Pueblo, Colorado (90 miles West of Ft. Lyon, 100 miles South of Denver) on January 31, 1983. A Medical Clinic (1½ days) is conducted every other week at the DAV Center. Mental health services as well as psychological and social work counselling services are provided (1½ days) on a weekly basis through the DAV Outreach Program located at the Job Service Center. All clinic patients are pre-scheduled, walk-ins are discouraged and only seen if schedule allows. The traveling team includes the coordinator and representatives from Medicine or Psychiatry Service, Nursing Service, Social Work Service, Psychology Service and Medical Administration Service.

Initial services being provided include:

- Medication reviews and other follow-up care for veterans already on the Ft. Lyon VAMC outpatient rolls.
- Limited physical examinations and appropriate referral to either the Ft. Lyon or Denver VAMC.
- Initial processing of new applications for veterans accessing the VA health care system for the first time.

- Direct mental health services as well as psychological and social work consultation.

It is noted that the Sheridan VAMC's earlier outreach follow-up clinic activities in the Billings, Montana as well as in Casper and Gillette, Wyoming areas was provided through non-recurring resources and have been discontinued pending receipt of recurring resources.

Residential Care services are provided by the Cheyenne, Denver, Ft. Lyon, Salt Lake City, and Sheridan VAMCs. These VAMCs are dispersed activity centers due to the considerable distances between the VAMCs and towns they provide residential care services for. See Attachment 3 as an example as to how dispersed the activities of Medical District 24 facilities actually are.

Attachments 4 through 7 provide a summary of Medical District 24 Outreach Clinic locations, activities and potential annual savings within Medical District 24 through implementation of the various outreach innovative health care delivery systems.

V. AFFILIATION SUPPORT

The Surgical Specialty Outreach Clinics conducted by the Salt Lake City VAMC Surgical Service are generally attended by residents on a rotational basis. Attending and conducting these clinics are considered to be part of their training and educational activities while on rotational assignment at the Salt Lake City VAMC. The Salt Lake City VAMC surgical staff feels that some of the very best teaching and operative cases come from these and other areas outside the Salt Lake City VAMC PSA. These physicians fly by charter or commercial flights to hold these clincs 287 and 477 miles away from home base. This is a unique opportunity for residents.

VI. ANALYSIS OF IMPACT

The innovative delivery systems presently utilized are, for the most part, still in the adolescent stage of development and implementation. The comments below reflect the District's experience to date.

Savings - Medical centers have experienced a savings in beneficiary air travel, lodger and patient escort expenses as a result of doing more initial patient evaluation and follow-up by specialists at the various surgical and medical outreach clinics.

Since one of the major objectives in establishing these innovative delivery systems was to reduce beneficiary travel expenses, a part of the design of these systems has been to return patients back to their "home" VAMC for follow-up, within the limits of that facility's capabilities. Along with this move was the responsibility of the "home" VAMC to provide any further diagnostic tests, medications, beneficiary travel to outreach specialty clinics, and other resources required by their patients. This resulted in some shifting of expenses and workload from tertiary medical centers to the "home" facility.

There are many variables involved which make it difficult to accurately identify all of the savings which occur. Such variables include:

- Differences amongst physicians in ordering diagnostic tests and prescribing treatment.
- Differences in the number of patients being seen in the newly established outreach delivery systems versus those that would have been sent (usually by air) to a tertiary or other medical center if we did not have these outreach systems.
- Difference in operational policies between medical centers.

Relatives usually serve as attendants to patients coming to these outreach clinics. Before establishing these outreach clinics, Medical District 24 had to hire attendants to accompany patients to a tertiary medical center.

It should be noted that a number of Outreach efforts have been made to improve medical accessability for the veteran patient within the constraints of available resources and for which an appreciable savings has not been identified.

Quality of Patient Care - Participating medical centers feel that the quality of patient care has been improved through the outreach programs. Specialized outpatient care is now available to patients in non-affiliated medical centers. The traveling specialists also see inpatients in clinics, hold patient care rounds, and conduct educational seminars for medical center staff. It has been noted that the traveling specialty VA consultants exhibit a much stronger commitment to medical care to the veteran than do non-VA consultants in the community. This commitment translates into a higher quality of care. Patients requiring specialty consultation are seen much earlier than previously, when the specialty clinics were held only at the tertiary site, resulting in shorter waiting lists and earlier medical intervention and rehabilitation. The degree of cooperation and communication between physicians in the tertiary and non-affiliated medical centers has grown significantly, resulting in more frequent and more immediate consultation requests and responses, and subsequently in increased quality of care. Participating medical centers feel the improved level in quality of patient care being realized on a district basis is a definite plus for both continuing and expanding the usage of this innovative health care delivery system.

Teaching Program - The screening of patients at these outreach surgical clinics to eliminate expensive and unnecessary patient travel to the Salt Lake City tertiary VAMC has resulted in more appropriate patient cases through more sensible referrals, many of which represent some of the very best inpatient teaching and operative cases for the surgical service. The affiliated resident teaching program has been expanded to include outlying specialty clinical experience which also has broadened the residents' exposure and association with other VA staff and local non-VA physicians in the treatment of patients. These clinics not only provide additional educational experience for the residents, but also for the professional staff at the non-affiliated medical centers. It has stretched the training dollars for these VAMCs through patient consultation and seminars made available to them. The chartered planes are large enough that seats are available for additional staff to be transported for educational purposes at no extra cost. VAMCs report that physicians at both affiliated and non-affiliated medical centers better understand what each other has to deal with and have a better understanding of the total picture involved between the two types of medical centers in meeting patient care needs. Medical centers feel that the teaching and education programs have definitely been enhanced through these outreach specialty clinics.

Working Relationships - Medical centers involved feel that these innovative outreach systems have enhanced esprit de corps and cooperation between MD 24 VAMCs. The benefits being realized seem to be pulling the system of VAMCs together in a "team approach" in the treatment of veteran patients.

Facilities - These innovative approaches seem to be relieving some of the congestion and burden in the outpatient departments at the tertiary medical centers as well as resulting in better utilization of excellent facilities available at the unaffiliated medical centers.

Patient Records - The screening of patients for referral to the tertiary care facilities for further care has reduced the number of patient folders transferred and the possibility for their loss. VAMCs reported they have had to "clean up" their act internally, in records retrieval.

VII. ISSUES FOR CONSIDERATION

Careful planning and a thorough review of potential issues are critical to the degree of success that will be achieved in meeting patient care needs most effectively and economically within resources available. From MD 24's experience thus far, the following issues or points are most salient when considering the implementation of innovative outreach health care delivery systems.

- Demographic and projected workload - A determination must be made as to the present and projected future patient care needs of the patient population served. The type, amount and frequency of patient care needs by specialty, beyond the maximum capability of a VAMC, must be identified before plans can be developed to most efficiently acquire the needed augmentation of specialty skills and assistance.

- Policy statements - Appropriate District policies should be developed to establish mutual understanding as to the operational aspects of outreach medical/surgical ventures. Conflicts in established policy statements at the individual medical centers must be resolved.

- Physicians workload and commitments already established at their assigned VAMC and University Medical Center.

- Administration's support and commitment to such outreach ventures.

- Type of facilities and diagnostic equipment available at or for clinic sites.

- Type of services to be provided at the clinics.

- Funding required, and source from which funding will be derived.

- Staffing support for clinics - what is needed and where will it come from.

- Transportation to and from outreach clinics - Who pays?

  Commercial flights present problems for physicians such as the hassle and inconvenience of travel paperwork, airline schedules, travel funds; motel accommodations; and transporting diagnostic equipment.

  Chartered flights permit physicians to fly to clinic sites, hold clinics and return the same day. However, some physicians feel the smaller charter planes are too risky, and refuse to fly in them. They much prefer the chartered jets which require the presence of a co-pilot and reduces unproductive time in the air. Empty seats should be designated for patient use to conserve funds.

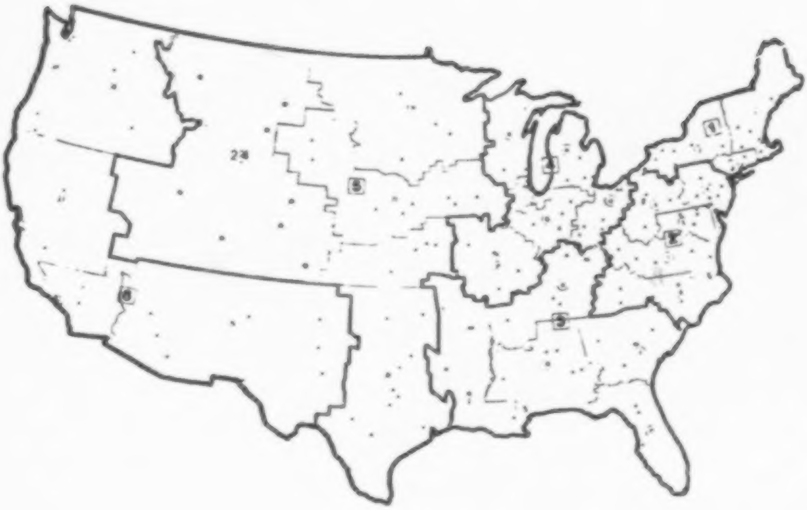
- Patient Education - It is important to explain to the patients any changes in beneficiary travel or in location of clinics, to alleviate apprehension and to minimize any detriment to the physician-patient relationship.

VIII. CONCLUSION

Each medical center, district and region is faced with differing resources and obstacles which must be approached based on their individual merits for effective resolution. A given set of approaches will not be appropriate or effective for all areas and, most likely, not any two areas.

The above represents Medical District 24's needs and approaches to fulfill them. The methods used are non-traditional. The geography and population dispersion, which require use of non-traditional approaches, are in themselves unique. As a Medical District, we must constantly be aware of changes and modifications needed in our operations and approaches in the MD 24 "team effort" to successfully meet the veteran needs at the most appropriate level and within the constraints of resources available, cost effectiveness and veteran eligibility requirements.

Medical District 24 (Shaded Area)

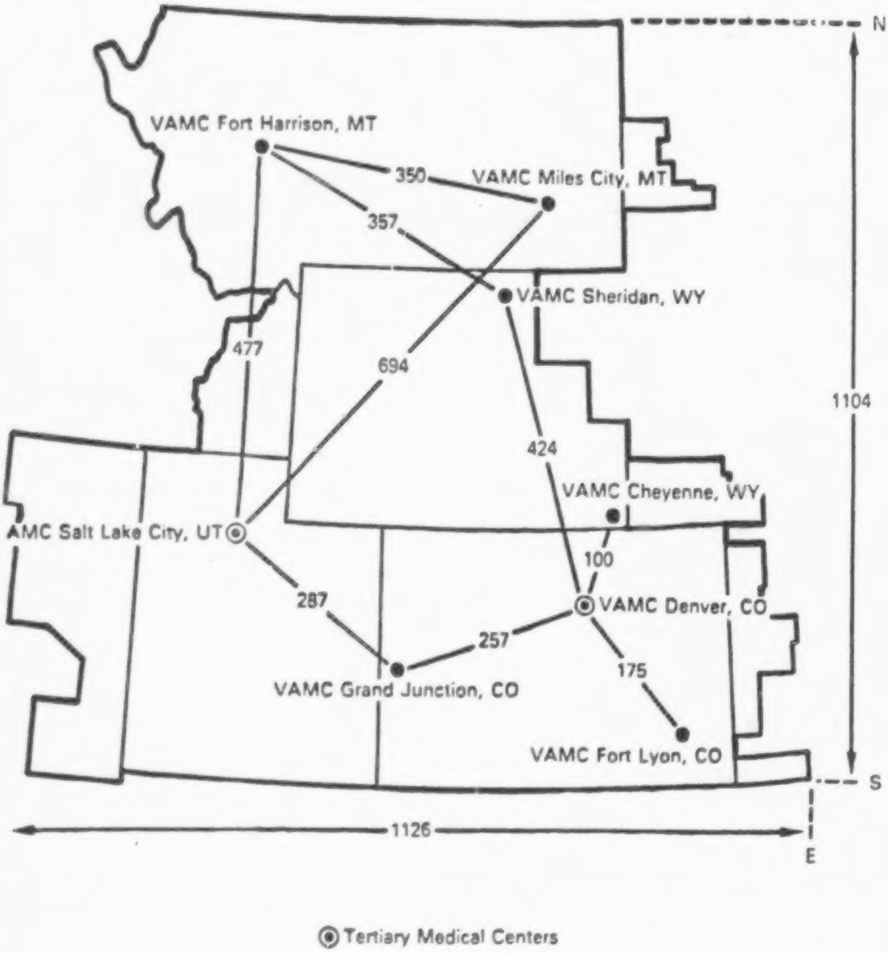


Geographical Area

- 205 Counties in 9 States
- 490,519 Square Miles
- 42% of Region 5 Territory (1,161,887 Sq. Miles)
- 14% of Total Cont'l. U.S. (3,537,010 Sq. Miles)

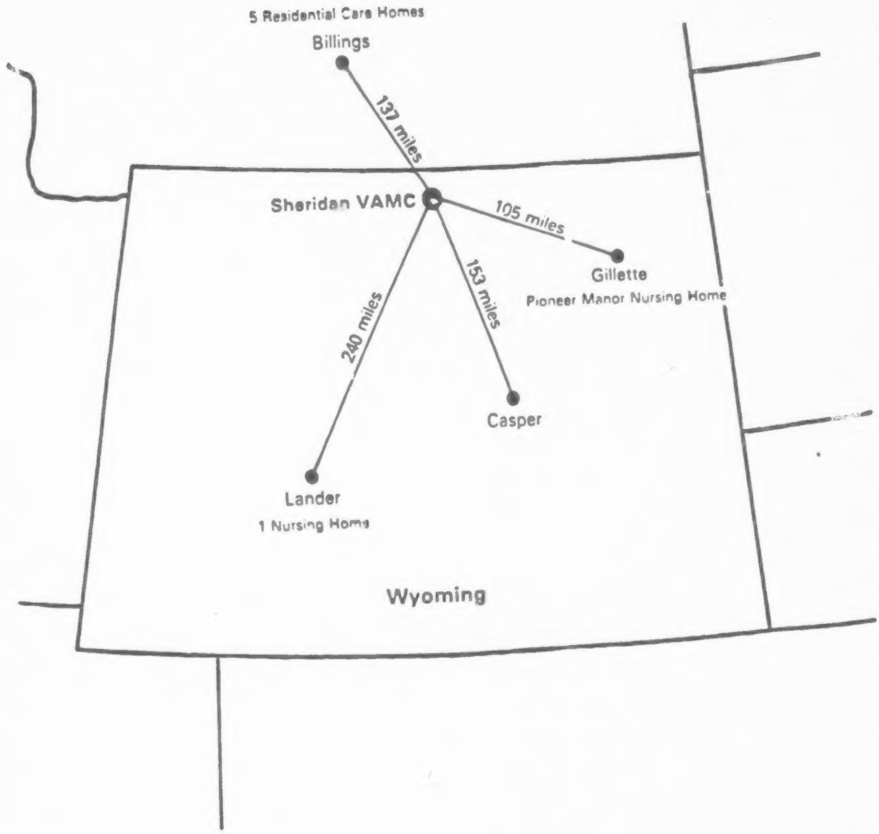
Attachment 2

MEDICAL DISTRICT 24 - GEOGRAPHICAL DISPERSION (in miles)


VAMC Fort Harrison, MT
350
VAMC Miles City, MT
357
VAMC Sheridan, WY
477
694
424
VAMC Cheyenne, WY
AMC Salt Lake City, UT
100
287
VAMC Denver, CO
257
175
VAMC Grand Junction, CO
VAMC Fort Lyon, CO
N
1104
S
1126
E
Tertiary Medical Centers

Attachment 3

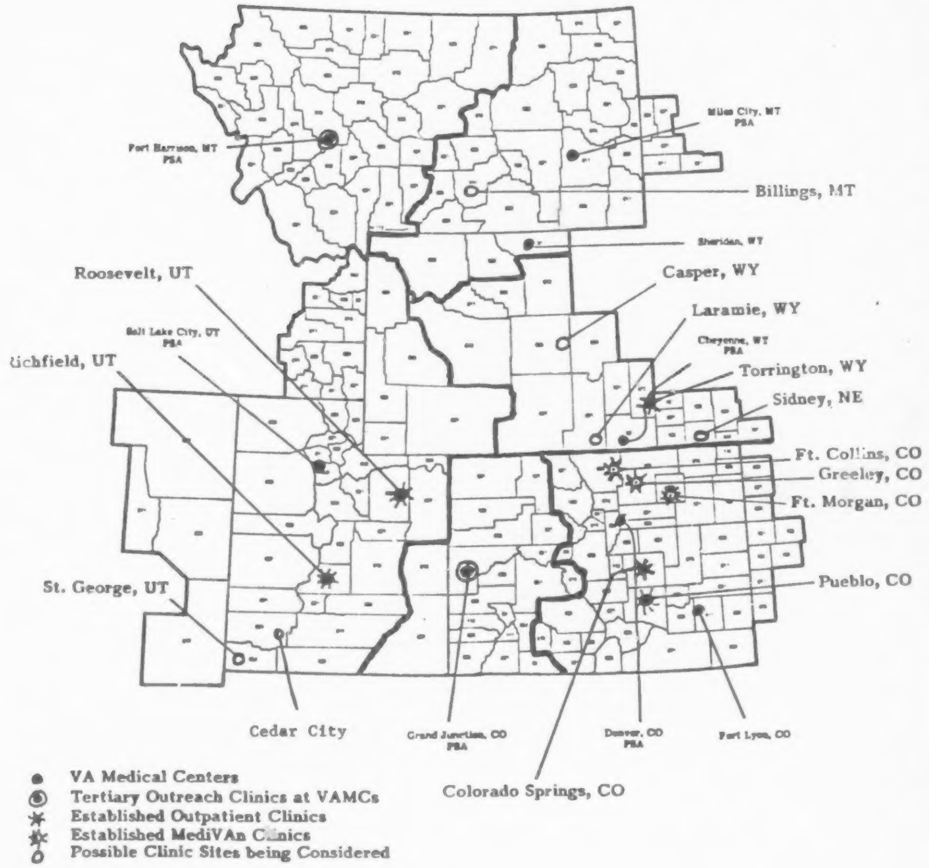
SHERIDAN VAMC - DISPERSED ACTIVITY CENTER


5 Residential Care Homes
Billings
137 miles
Sheridan VAMC
105 miles
Gillette
Pioneer Manor Nursing Home
153 miles
240 miles
Casper
Lander
1 Nursing Home
Wyoming

Attachment 4

MEDICAL DISTRICT 24 PSAs

Medical Centers and Outreach Clinics Sites


Miles City, MT PSA
Fort Harrison, MT PSA
Billings, MT
Sheridan, WY
Roosevelt, UT
Casper, WY
Laramie, WY
Salt Lake City, UT PSA
Cheyenne, WY PSA
ichfield, UT
Torrington, WY
Sidney, NE
Ft. Collins, CO
Greeley, CO
Ft. Morgan, CO
St. George, UT
Pueblo, CO
Cedar City
Grand Junction, CO PSA
Denver, CO PSA
Fort Lyon, CO
Colorado Springs, CO
● VA Medical Centers
◉ Tertiary Outreach Clinics at VAMCs
✱ Established Outpatient Clinics
✱ Established MediVAn Clinics
○ Possible Clinic Sites being Considered

Attachment 5

TERTIARY OUTREACH CLINICS

Conducted by VAMC, Salt Lake City

October 1, 1980 - September 30, 1982

FORT HARRISON	Total # Clinics	Total Patients Seen	Average # Per Clinic	Percent "No Show"	Patient Limit Per Clinic
Neurosurgery	26	276	10.6	19%	12
Ophthalmology	24	482	20.1	16%	25 (2 das.) 15 (1 dr.)
Optometry (begun 1/82)	9	64	7.1	23%	10
Orthopedics	27	601	22.3	22%	30 (2drs.) 18 (1dr.)
Urology	23	304	13.2	20%	20
Vascular Surgery	24	357	14.9	9%	24
ENT (Discont.)*	12	69	5.0	18%	
TOTAL	145	2,153	14.9		
GRAND JUNCTION					
ENT	24	440	18.3	14%	21
Neurology	21	139	6.6	30%	8
Neurosurgery	19	161	8.5	10%	12
Urology	45	807	17.9	13%	18
Ophthalmology (begun 9/82)	1	16	16.0	11%	18
Optometry (begun 12/82)					
Physiatry (begun 10/82)					
TOTAL	110	1,563	14.2		

*Discontinued 11/81 - Local specialist conducts the clinic

Attachment 6

MEDIVAN OUTREACH CLINICS

Conducted by VAMC, Denver

Characteristics of MediVAn Sites	Colorado	Greeley	Fort Morgan	Fort Collins	Colorado Springs
Distance from the Denver VAMC (miles)	--	53	79	63	67
Catchment area					
square miles	103,767	4,002	8,005	2,611	7,413
population, 1978 est.	2,664,000	109,400	55,700	128,400	446,000
veterans, 1977 est.	360,000	23,620	6,560	13,350	59,880
% rural population	21.5	53.6	59.2	33.8	14.2
travel to physician's office - % greater than 30 min.	14.6	18.7	18.3	18.7	14.3
MD's / 100,000	174	113	66	136	134
Internists / 100,000	22	9	2	10	16
MediVAn Team Clinic Activities - FY 81-82					
ndividual patients seen in clinics		136	185	188	257
Total clinics held		62	95	86	100
Total patient visits		666	1,252	1,210	1,963
Average patients per clinic*		10.7	13.2	14.1	19.6

*Average no-show rate for all four MediVAn team clinics is 14%

Attachment 7

SUMMARY OF POTENTIAL ANNUAL SAVINGS

Actual - FY 1982

Tertiary Outreach Clinics:	
Fort Harrison, Montana	$ 184,700
Grand Junction, Colorado	66,400
MediVAn:	
Greely, Fort Collins, Fort Morgan, Colorado	17,000
Subtotal	$ 268,100

Projected Annual Savings - New Programs

Free Standing Clinics:	
Colorado Springs, Colorado	$ 310,000
Travelling Follow-up Clinics:	
Torrington, Wyoming	2,500
Rural Health Outreach Clinics:	
Roosevelt	-
Richfield	-
Subtotal	$ 312,500
TOTAL	$ 580,600

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

NURSING EDUCATION AUDITORIUM

AT

DENVER, COLORADO

OCTOBER 22, 1983

STATEMENT OF

CARLTON M. SMITH

MEDICAL CENTER DIRECTOR

V. A. MEDICAL CENTER

DENVER, COLORADO

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of testifying before your committee. I will address the programs and activities of the VA Medical Center, Denver, Colorado.

INTRODUCTION:

I would like to present a brief overview of our mission and services and then address the major subject of this hearing on delivery of quality health care to veterans in remote isolated geographic areas of Colorado and bordering states. Outreach programs, beneficiary travel and sharing affected by geographic distances will be described.

The patient programs include primary, secondary and tertiary medical, surgical, neurological and psychiatric inpatient care. Services provided by the DVAMC include: 268 operating beds (401 operating beds post construction), 32 specialty and subspecialty clinics, 22 special medical programs (Attachment 1), 1 satellite clinic, 1 MediVan for remote visits (Fort Collins, Fort Morgan and Colorado Springs) and 1 charter airline to Fort Lyon for patient care staff transportation.

On site services are provided to the 364,220 veterans in DVAMC's primary service area, (PSA), 42 Colorado counties, 7 Kansas counties and 2 Nebraska counties. Approximately 19.5% of DVAMC's workload is generated by veterans residing outside the PSA.

During fiscal year 1983, 10,219 veterans were admitted to the DVAMC and 143,472 outpatient visits took place.

DVAMC is also the Clinic of Jurisdiction for the State of Colorado. During FY 1983, the following clinic of jurisdiction services were provided: 22,354 fee outpatient visits by community physicians, 49,587 fee prescription for drugs and supplies filled by VA staff, 156 fee prescription for drugs and supplies filled by community pharmacists, 765 days of private hospital care and 343 fee dental cases completed by community dentists.

Approximately 96 veterans were placed in community nursing homes, 119 veterans were in two (2) State Nursing Homes and 59 veterans were in the Homelake Domiciliary at VA expense at the end of Fiscal Year 1983.

The major affiliate is the University of Colorado Health Sciences Center.

41 medical investigators are researching 77 projects including multiple sclerosis, renal disease, diabetes, alcoholism and immunology of liver disease. The current research budget exceeds $1,800,000. 175 research articles were published during Fiscal Year 1983.

RESPONSIBILITY OF DVAMC AS A REFERRAL MEDICAL CENTER

DVAMC is a major referral center for patients residing in the Rocky Mountain area. Veterans are referred by VAMCs at Fort Lyon and Grand Junction, Colorado; Cheyenne and Sheridan, Wyoming; Miles City and Fort Harrison, Montana and Fort Meade and Hot Springs, South Dakota. Of the 10,219 admissions in Fiscal Year 1983, 6.5% were veterans transferred from these VAMCs. DVAMC places special emphasis on providing the fullest range of health care services in support of the other VAMCs within the Rocky Mountain Region and maintains a responsive referral system to facilitate access to care.

GEOGRAPHICAL OUTREACH TO VETERANS

DVAMC provides outreach services to veterans living in remote areas. Both the MediVan and the chartered aircraft to Fort Lyon VAMC have provided outreach services for over five years. The Colorado Springs Clinic was established in 1981.

The mobile internal medicine clinic (MediVan) is equipped with an examining room and mini-lab. The MediVan's staff (a physician, registered nurse, nurse practitioner and coordinator) provide patient care services in Fort Morgan, Fort Collins and Colorado Springs weekly. In the five operative years the MediVan staff completed 9,925 patient visits, averaging 50 visits per week. The MediVan program generates an average of 13 patient referral visits per month to DVAMC. Facts show this mobile medical clinic is a cost effective and convenient method of delivering primary care to remote areas.

A chartered aircraft transports 5 professional staff between DVAMC and Fort Lyon VAMC each Wednesday. Routine travelers are a psychiatrist, psychologist, podiatrist, social worker, prosthetics representative and nursing education personnel. The staff provides specialized medical care and training for veterans in the Fort Lyon community.

The Colorado Springs Satellite Clinic provides 6 outpatient services for eligible veterans: Mental Hygiene, Medical, Dental, Vietnam Veteran Outreach, State Employment Counseling and Vocational Rehabilitation and Counseling. The average patient caseload is 40-45 visits per week. Patients requiring inpatient care are referred to DVAMC.

BENEFICIARY TRAVEL

Veterans living in outlying remote areas are generally paid common carrier (bus) rates. Mileage (currently .11¢ per mile) is paid to veterans who must drive their own vehicles when medically indicated. Air travel is provided for veterans who cannot medically tolerate ground transportation. Approximately $497,000 was spent for beneficiary non-local travel for 25,515 trips in FY 83. This non-local travel represents 78.8% of the beneficiary travel budget.

CONCLUSION

I believe the Denver VA Medical Center is providing quality services to veterans in the nearby community and in remote isolated locations in a cost efficient manner.

Attachment 1

DESCRIPTION OF SERVICES

VA MEDICAL CENTER
DENVER, COLORADO

October 22, 1983

MEDICAL SPECIALITIES

Allergy & Immunology
Anesthesiology
Cardiovascular Disease
Dermatology
Diagnostic Radiology
Endocrinology and Metabolism
Gastroenterology
General Internal Medicine
General Surgery
Hand Surgery
Hematology
Infectious Disease
Nephrology
Neurology
Nuclear Medicine
Oncology
Ophthalmology
Orthopedic Surgery
Otolaryngology
Pathology
Plastic Surgery
Psychiatry
Pulmonary Disease
Rehabilitation Medicine
Rheumatology
Urology

SPECIAL MEDICAL PROGRAMS

Alcoholic Treatment Center
Cardiac Catheterization
Cardiovascular Surgery
Coronary Care Unit
Day Hospital Program
Drug Dependence Treatment Unit
Electron Microscopy Program
Hemodialysis Program
Home Dialysis Program
Hospital Based Home Care
Medical Intensive Care Unit
Mental Hygiene Clinic
Nuclear Medicine Progtam
Palliative Treatment Program
Prosthetic Treatment Center
Psychiatric Emergency Service
Pulmonary Function
Rehabilitative Gerontology
Respiratory Care
Speech Pathology
Surgical Intensive Care Unit

FY 83 STATISTICAL PROFILE

VA MEDICAL CENTER
DENVER, COLORADO

Admissions	10,219
Average Daily Census	276
Average Length of Stay	12
Occupancy Rate	86
Patients Treated	11,190
Turnover Rate	331

STAFF OUTPATIENT VISITS

Denver	139,782
Colorado Springs	3,690
Total Staff Visits	143,472

Agent Orange Exams	119
Nuclear Radiation Exams	3
POW Exams	16

Fee Prescription Filled by VA Staff	49,587
Fee Prescription Filled by Fee Pharmacists	156
Fee Outpatient Visits	22,354
Fee Hospital Days of Care	765
Fee Dental Cases Closed	343

Community Nursing Home ADC	72.84
State Homes ADC	121.59
State Domiciliary ADC	54.41

SPECIFIC COSTS

MediVan Expenses (Gas & Repairs)	$ 7,284
Outreach Contract Costs	$239,689
Beneficiary Travel Costs	$630,986
*Sharing Costs	$442,466
*Excludes Misc. N/Sharing CP 033	$ 54,600

MEDIVAN

Average number of patient visits per week: 9,925 visits since 1979

Colorado Springs	24
Fort Collins	17
Fort Morgan	17

Average 21-27 laboratory tests performed per week

Average 13 referrals per month to DVAMC